AMMIS Provider Services Operations Manual

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Table of Contents

1 DOCUMENT CONTROL

The latest version of this document is stored electronically. Any printed copy has to be considered an uncontrolled copy.

1.1 DOCUMENT INFORMATION PAGE

Required Information	Definition
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1.2 AMENDMENT HISTORY

The following Amendment History log contains a record of changes made to this document:

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2/25/2016	12.0		Enrollment Procedure Changes	4.1.4 and various sections related to CHOW procedures
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09/30/2016	14.0		General updates	3.9, 4.1, 4.2.1 to 4.2.2, 4.2.4 to 4.2.6, 4.2.9 to 4.2.11, 4.2.15 to 4.2.16.
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08/11/2017	16.0		Update to Optometrist section	4.1.25
09/20/2018	17.0		Global updates	
10/11/2018	18.0		Added approved specialty 274 Dental Prevention to provider types 56, 58, 31, 10, 57, 13, and 09 (Physician employed & Independent Nurse Practitioners).	

1.3 RELATED DOCUMENTATION

Document	Description	url

2 INTRODUCTION

2.1 OVERVIEW

To ensure that the Medicaid recipients have access to quality health care, the Provider Services unit must correctly and promptly enroll providers, respond courteously to provider inquiries, and organize training sessions for the providers. Provider Services has the responsibility to introduce providers to new technology or new guidelines that will change how the providers work with the program. Provider Services also works with providers on a one-on-one basis to resolve issues.

2.2 UNIT FUNCTIONS

Provider Services is comprised of three functional units:

Provider Enrollment

Provider Representatives

Provider Assistance Center

2.3 PROVIDER SERVICES TASK

The following list identifies the tasks that Provider Services units most frequently perform:

Maintain, update, and change the Provider Table with new or modified provider data.

Receive updates from the Agency or providers and apply them to the Provider Table.

Verify required licenses and certifications–including specialty credentials–with the appropriate regulating and accreditation agencies.

Staff and operate a Provider Assistance Center (PAC) from the hours of 8 am to 5 pm local time, Monday through Friday. These time frames exclude DXC-observed holidays.

NOTE:

No DXC holiday can be taken unless also observed by the Alabama Medicaid Agency.

Perform provider enrollment activities.

Advise providers on the process for enrollment into the Automated Eligibility Verification and Claims Management (AEVCS) system.

Perform problem solving with the providers.

Perform system testing.

Provide electronic enrollment application for providers.

Process all applications within Agency-defined standards.

Send notification letters of acceptance or rejection to prospective providers.

Respond to State legislature or State executive inquiries within the State-defined time frame. (In most cases, the response requires approval by the Medicaid Agency before it is sent).

Conduct provider training, and deliver ongoing provider training based on the Agency-approved annual provider training plan.

Furnish on-site assistance to providers that have billing difficulties when requested by the Agency, the provider, or other departments within DXC (such as the Provider Assistance Center).

Attend provider association meetings and annual conventions.

Develop, print, and distribute provider manuals, updates, and bulletins to the providers.

In Provider Services, a key ingredient to success is follow-up with all customers—providers, provider associations, the Agency, and the State offices. Provider Services must provide prompt, efficient, and reliable service to all of these entities. If an answer to the inquiry is not readily available, Provider Services personnel must research the inquiry and return an answer to the customer as rapidly as possible.

2.4 INPUT, PROCESSES, AND OUTPUT

Input

The table below documents the most common inputs to the Provider Services functional area:

Common Provider Services Input

Input	Source	Purpose
Agency correspondence	Agency	To request information and status on the AMMIS system. To provide requested answers to Provider Services.
Provider correspondence	Provider	To request information about various Medicaid questions. To provide updated information on the Provider, such as name or address change.
Provider requests for enrollment	Potential provider	To request enrollment in the Alabama Medicaid program.

2.4.1 Processes

Provider Enrollment

The Provider Enrollment process enables potential providers to enroll in the Alabama Medicaid system. This process includes the following:

Providing an electronic provider enrollment application on the interactive web site.

Acceptance or denial of the provider application.

Distribution of provider materials—Provider Manual, Provider Billing Manual, provider bulletins, and provider manual updates—to the provider.

Provider Support

Provider Services supports the providers in several ways. The department staffs 16 toll-free telephone lines that enable the provider to get immediate help for Medicaid related issues. Provider Service Representatives work with the provider to provide education, training, and to resolve issues with the Medicaid process.

Provider Support also supplies updated documents to the providers on a regular basis. These documents include the following:

Provider Manual

Provider Billing Manual

Bi-monthly provider bulletins

Updates to the Provider Manual and the Provider Billing Manual documents

The Technical Writing Department is responsible for ensuring that documents found on the Alabama Medicaid Web site–*http://www.medicaid.alabama.gov* are current and accurate.

2.4.2 Output

The table below lists typical outputs from the Provider Services functional area.

Common Provider Services Output

Output	Source	Purpose
DXC correspondence	Provider Services	To communicate a response to Agency correspondence. To communicate a response to provider correspondence. To provide updated information to the Agency and to providers.
Provider Billing Manual	Provider Services	To provide the latest Alabama Medicaid billing information to providers.
Provider Bulletin	Provider Services	To update the Provider Manual that is supplied to providers with the latest information from the Agency.
Provider Manual	Provider Services	To provide the information necessary for a provider to submit claims and obtain information from Alabama Medicaid.
Provider Table updates	Provider Services	To update the Provider Table with approved provider changes.

2.5 FUNCTIONAL AREA RESPONSIBILITIES

The following responsibilities for the Provider Services functional unit were extracted from section 3.02 of the Invitation to Bid (ITB).

Provider Enrollment

1. Perform enrollment activities for all provider types, both contract and non-contract providers. Maintain facility ownership information as a function of provider maintenance. Maintain knowledge of all applicable federal and state provider enrollment and certification regulations, and develop and establish detailed guidelines and procedures for State approval to ensure proper enrollment of all provider types.
2. Receive requests for enrollment and mail all enrollment packets to providers.
3. Accept and process provider enrollment applications in the format specified by the State.
4. Research and compile all information relating to the Provider appeals process for provider enrollment rejections, terminations, and changes to program participation eligibility effective dates in accordance with State guidelines. Submit the material to the State for its use in the provider appeals process.
5. Notify providers by letter of acceptance/rejection as a State provider, and send a start-up packet to approved providers containing all necessary information, forms and/or software needed to bill for Medicaid services for eligible recipients.
6. Contractor will use taxonomy code and location code to match National Provider Identifier (NPI) number to current Medicaid Provider ID.
7. Maintain agreements for billing agencies. This includes:
   Administration access for creating, deleting, setting permissions and resetting passwords for all trading partners. User access for updating their profile to better fit the user's needs.
8. Maintain and update the relationships between group practices and group members.
9. Maintain provider enrollment personnel with a minimum of five (5) full-time equivalents (FTE)-enrollment specialists of which one (1) must be a Managed Care enrollment specialist, one (1) FTE –enrollment quality assurance specialist and one (1) enrollment supervisor.

2.5.1 Certification/Recertification

1. Process, record, and track, using an automated tracking system, all sanctions and intermediate sanctions against providers, per State specifications, as initiated by CMS (Center for Medicare and Medicaid Services), the federal OIG (Office of Inspector General)or State. The record shall include the provider's full name and address, social security number, license number, date of sanction, and length of sanction from written reports produced by CMS, or any other government agency. Compare the automated file to the master provider file weekly and report matches to Medicaid for further action.
2. Perform certification and recertification activities, as appropriate and directed by the State, to ensure that all Alabama Medicaid providers maintain required certifications for participation in the Medicaid program.
3. Maintain regular communications with the applicable state agencies and licensing organizations to perform certification and licensure verification, including licensure of out-of-state providers; where appropriate, perform electronic data exchanges. Applicable agencies and organizations include the Department of Public Health, the State Board of Medical Examiners, the Joint Commission, and the State Boards (Dental Examiners, Optometry, Nursing, Speech, Occupational and Physical Therapy, Chiropractors and Podiatrists).
4. Upon publication of new licensure information, verify licensure for all instate providers enrolled by Contractor. Update the master provider file with appropriate end dates and deactivate all enrollments for any provider identified as no longer being licensed or certified.
5. Certify electronic media and tape billing services as automated billing service vendors. Run a test submission prior to certification to ensure that the submission format is accepted by the Alabama MMIS.

Provider Communications/Customer Relations/Inquiry

1. Maintain and staff a provider communications/relations inquiry function to include toll-free lines that are staffed from 8:00 a.m. to 5:00 p.m. local time, Monday through Friday (excluding State-observed holidays). A minimum of sixteen (16) (FTE) staff shall be provided to answer sixteen (16) toll-free telephone lines (with the capacity of up to forty (40)). If additional staff is required, reimbursement will be made in accordance with Section 50.141 of this ITB.
2. Provide a call management system or supply phone company reports of all line activities, busy signals, hang-ups, non-connects, and internal reports of number of calls answered, number of calls put on hold, and the length of time each call was held.
3. Train all Contractor provider relations staff in billing procedures, current Alabama Medicaid Program policy, and telephone inquiries.
4. Receive, track and promptly respond to all verbal inquiries on claim status, prior authorization status, billing problems, billing procedures, Medicaid policy and remittance advices immediately, if possible, or in accordance with defined performance expectations.
5. Track and respond in writing to all written correspondence, including inquiries on claim status, billing problems, billing procedures, and remittance advices, in accordance with defined performance expectations.
6. Retain copies of all written correspondence in the appropriate files.
7. Provide the State with monthly and annual reports summarizing all calls answered and timeliness of written correspondence, according to State specifications.

Provider Training/Representatives

1. Employ sufficient staff to perform quarterly and on-request provider training responsibilities. At a minimum, provide at least thirteen (13) Medicaid-dedicated, full-time provider field representatives, one of which shall be designated as a supervisor, to provide quarterly and on-request training and to assist providers in understanding program policy, the responsibilities of managed care providers, the submission of claims and in the resolution of claims processing problems. A designated number of provider representatives shall be assigned to specific program areas by the State.
2. Employ one (1) full-time EMC coordinator and three (3) EMC full-time staff to provide training, assist providers in the submission of claims and in the resolution of claims processing problems.
3. Ensure that provider field representatives and Inquiry/Customer Relations staff are sensitive to provider training and inquiry needs. Field representatives shall be willing and able to provide on-site support to a provider whenever requested, within a reasonable period of time. Provider representatives should meet individually with designated Medicaid program staff at least monthly.
4. Develop provider training materials and obtain Alabama Medicaid approval of the materials prior to use in the provider training programs.
5. Assume responsibility for all logistical arrangements, training materials, and space costs for provider training.
6. Conduct provider training and training for State-designated organizations at State approved locations.
7. Provide special in-depth training to providers who have been identified (by the Contractor, by Alabama Medicaid, or the provider's association) as having an abnormal number of claims denied or suspended, repeated problems with certification or recertification, an abnormal number of problems using the contractor's systems, underutilization of required immunizations, underutilization of EPSDT screenings and referral requirements and inappropriate patterns as reflected on provider report cards.
8. Develop, distribute, and evaluate provider training questionnaires from all training sessions, and provide the State with a summary of provider responses.
9. Maintain regular contact with all professional associations of health care providers in Alabama Medicaid to promote provider understanding of the Alabama Medicaid program.
10. Develop, and make available, software free of charge, including all future updates, for providers to submit electronic media claims (EMC) data via personal computer, electronic transfer, diskette, or magnetic media. The Contractor shall make available the software updates on the Medicaid WEB Site for downloading by providers.
11. Provide support, including on-site training if required, to instruct providers in using electronic claims submission software or to facilitate the resolution of billing problems.
12. Develop and implement a testing process for providers who wish to begin submitting electronic media claims to ensure provider competency before allowing EMC transmission.
13. Develop a training plan annually at the beginning of the contract year and update the plan as necessary throughout the year.

2.5.2 Provider Manuals/Bulletins/Notices

1. Write and obtain State approval of, print, and distribute the provider billing manual and provider bulletins. The provider billing manual shall be available on CD-ROM. Copies shall be sent to all providers, all provider associations, the State, and other entities specified by the State, with the number of copies determined by the State.
2. Maintain the provider billing manual in a format that facilitates updates and includes step-by-step billing instructions.
3. Update the provider billing manual on an as-needed or State-requested basis. Updates must be made by full page replacements.
4. Develop, modify, print, and distribute to providers, at no charge, all non-standard claim forms and attachments approved by the Medicaid Program.
5. Work closely with the State to develop provider manual and bulletin formats.
6. Provide the capability to electronically transmit/distribute as specified by the State all provider notices that are prepared by the State.
7. Issue provider bulletins every two (2) months to alert providers of program and/or billing changes.
8. Produce and mail other provider notices, in a format designated by the State, with bulletins, manuals, enrollment packages, or as an individual mailing as directed by the State. These would be notices other than bulletins such as letters, flyers, etc.

2.5.3 Provider Table/Database

1. Maintain a Provider Table/database in which each provider identified by their NPI and includes all data elements currently required by the State, including national provider identifier.
2. Update the Provider Table on a daily basis to reflect changes brought to the attention of the Contractor by the State, providers, or from within DXC.
3. Perform quality assurance of data in the Provider Table and submit results to the State in accordance with Agency instructions. Provider surveys, returned mail, comparison to yellow pages, etc. shall be utilized to verify the accuracy of data such as addresses and phone numbers.
4. Support all provider functions, files, and data elements necessary to meet the requirements of the ITB.
5. Provider Table update access will be limited to designated personnel.
6. Conduct mass updates of the provider file accommodation rates when directed by Medicaid.
7. Establish methods to edit and verify accuracy of provider data as entered on screens.
8. Identify all categories of service and specialties that a provider is allowed to bill, including effective dates.
9. Generate all State-required Provider reports that are currently produced.
10. Establish accounts receivable balances based on claims credits and instructions from the State.
11. Update the accounts receivable balance or percentage withheld for a provider when directed by the State.

12. Produce data for provider audits and quality assurance.
13. Make recommendations on any area in which the Contractor thinks improvements can be made.
14. Notify the State, in writing, of suspected provider fraud or provider billing errors resulting in overpayment.
15. Submit to the State on a timely basis all provider reports according to the schedule determined by the State.
16. Interface with or utilize the National Provider System being developed by CMS in accordance with directions from Medicaid. CMS has not published final rules on NPS. Medicaid understands that on-line access will be available to the NPESS for verifying NPIs and for the registering of new providers who need an NPI. Federal law requires all providers that provide medical services to be enumerated.
17. Maintain an audit trail of all update transactions applied to the Provider Table.
18. Provide a daily provider file update report to cover update transactions for the previous day.
19. Maintain all demographic and rate information to support claims processing and reporting functions as is currently done and/or needed for NPI.
20. Maintain, and coordinate with Medicaid, updates to the institutional rates on the Provider Table.
21. Maintain and update the provider's Medicare number.
22. Maintain a cross-reference of Medicaid-Medicare provider numbers to support crossover claims processing.
23. Provider on-line inquiry and real-time update access to the Provider Table. Update access will be limited to designated personnel.

2.6 PERFORMANCE EXPECTATIONS

The following performance expectations for the Provider Services functional unit were extracted from section 3.02 of the Invitation to Bid (ITB):

1. Mail all provider enrollment packets within two (2) business days of receipt of the request.
2. Process (approve or deny) provider applications and updates within five (5) business days of receipt. If additional information is required from the provider, an additional five (5) business days is allowed to obtain the information and process the application.
3. Add new providers, according to State guidelines, to the provider table/database within two (2) business days of enrollment approval.
4. Maintain all provider enrollment files on COLD.
5. Update the Provider File/Database on-line within two (2) business days of receipt of change requests from any source. If additional information is required from the provider, an additional three (3) business days is allowed to obtain the information and process the change request.
6. Develop and submit to the State for approval, an annual provider training plan within ten (10) business days of the beginning of each contract year and within three (3) business days of updating the plan as necessary.

7. Conduct provider training at least quarterly by claim or provider type or as requested by the State.
8. Mail claim forms and other billing documents to providers within five (5) business days of receipt of the request for forms.
9. Mail provider billing manual, (CDs and paper copies) within twenty (20) business days of approval by the State.
10. Mail provider bulletins and billing manual updates (CDs and paper copies) within ten (10) business days of approval by the State.
11. Maintain and update monthly the Patient 1st PMP lists by county on the website for recipient use.
12. Staff provider communications/relations phone lines from 8:00 a.m. to 5:00 p.m. local time, Monday through Friday on all State business days.
13. Respond to all calls and telephone contacts by the end of the next business day.
14. Respond in writing to written correspondence within seven (7) business days of receipt.
15. Update the Provider Master Data Base with renewal information within five (5) business days of verifying licensure or certification.
16. Provide the State with monthly reports on all calls answered, the nature of the inquiries, and the timeliness of responses to correspondence for the prior month's activity.
17. Update Provider Subsystem user manual within the schedule determined by the State.
18. Submit to the State on a timely basis all Provider Subsystem reports according to the schedule determined by the State.
19. Execute provider contract letter and mail any needed materials within two (2) days of enrollment approval.

3 PROVIDER ENROLLMENT INSTRUCTIONS

Provider Enrollment is the process of determining whether a prospective provider meets the standards for providing services and/or supplies to Medicaid recipients, and then adding the provider to AMMIS. The Alabama Medicaid program provider enrollment procedures are designed to ensure timely, efficient, and accurate processing of Provider Enrollment applications.

Payments are made only to providers who have been enrolled in the Medicaid program and only for necessary and reasonable medical care. A provider must be licensed, registered, or certified by the appropriate professional regulatory agency according to state or Federal law, or must be authorized by the Agency administrating the Medicaid program.

3.1 PROVIDER ENROLLMENT OPERATIONAL PROCEDURES

The process begins when a Provider Enrollment specialist receives a request from a potential provider for enrollment as a Medicaid provider. Requests from providers can be submitted to Providers Services by the following methods:

E-mail submitted through the Alabama Medicaid Web site

Fax

Telephone

Written Request

The following steps determine the enrollment process:

> The Provider Enrollment application must be processed–approved, denied, or returned to provider for corrections–within five business days of the initial receipt of the application.

1. The provider accesses the electronic enrollment application on the interactive web site.
2. The provider completes and submits the electronic application.
3. A facsimile of the application is created and held in the Feith workflow pending receipt of the required agreement and documentation.
4. Provider faxes the completed agreement and the required documentation with the bar-coded fax cover sheet to 334-215-7416
5. The provider sends the completed agreement and the required documentation with the bar-coded fax cover sheet to the Provider Assistance post office box (P. O. Box 241685).
6. The courier retrieves the documentation from the post office and delivers the documentation to the DXC mailroom.
7. The mailroom forwards the documentation to Provider Enrollment.
8. A Provider Enrollment clerk prepares the mail as follows:
    a. Open the mail.
    b. Separate the correspondence from agreements.
    c. Stamp each page of the document with a date stamp.
    d. Scan agreements into COLD.

e. Place scanned agreements in the appropriate pending tray.

9. Workflow will assign the application to a PE Clerk when the required documentation is received. Assignment will be based on provider type; number of applications received that day and the number of available clerks.

A Provider Enrollment clerk will:

10. Confirm that the agreement and required documentation have a valid signature and matches the submitted electronic application.
11. Request required corrections or follow-up on incomplete documentation.
12. Generate return email with appropriate return reason(s) and updates the electronic application with the appropriate return status.
13. Update workflow with Return to Provider (RTP) status
14. Verify provider credentials.
15. Maintain a mainframe file, which contains all usable Medicare Exclusion Database (MED) information, and specific sanctions/exclusions directed by Medicaid. Maintain an automated system edit, which will deter the enrollment of providers who have an SSN or FEIN that matches the information contained in the mainframe file.
16. Utilize the Provider Information Search Page or Provider Mini-Search Panel to search for possible existing Medicaid enrollments. Use the following search elements to see if the provider is currently enrolled:

License number

SSN

Provider ID

Federal Employer Identification Number

Provider name

Medicare provider number

17. After it is determined that the provider is not currently enrolled in the Alabama Medicaid program at the location on the application, Provider Enrollment will update the application status to approved and a batch process will move all data to AMMIS. Refer to the individual enrollment sections to determine if additional information is required.
18. Provider notification letters are generated each night.
19. Operations personnel deliver the notification letters to the Provider Enrollment unit each morning.
20. Provider Enrollment Specialist, using the enrollment application, verifies the data in the notification letter.
21. Mail the notification letter, provider manual and other required materials to the provider. Send a provider manual only to newly enrolled groups and to new providers that are not members of a group. Do not send a provider manual to providers that have been added to an existing group.

Notification and materials must be sent to the provider within two business days of the enrollment approval.

The provider must be added to the AMMIS within two business days of the enrollment approval.

3.2 PROVIDER FILE UPDATES

The provider must be updated to the AMMIS within two business days of the receipt of change requests sent to DXC via mail, e-mail or FAX.

3.3 PROVIDER FILE INFORMATION UPDATES AND COMMUNICATION (I2004 E24S)

DXC provides a method for provider notices/alerts to be sent out electronically via email or facsimiles to providers/vendors who choose to participate in electronic delivery option.

Documentation, such as responses to surveys and submission of the on-line update form, will be used to update provider information and add vendors as non-providers (A non-provider is a vendor that is in the provider file for mailing purposes only). All vendors must be on file as a non-provider to receive distribution of notices or alerts. Non-providers are identified by the number scheme NPxxxxxxP where xxxxxx are the next sequential numbers available. Non-providers submit a written request giving address, fax and telephone information, which is used to add the non-provider number. However, surveys will initially be sent to providers and vendors.

An on-line update form is on the Alabama Medicaid website for detailed informational updates. A simplified version is also available for providers who only want to make the distribution method election. To use these forms the provider/vendor accesses the Alabama Medicaid website, opens and completes one of the forms. The on-line form is printed, signed and submitted to DXC via facsimile or mail. Provider information is received by Provider Enrollment and is used to manually update the Provider Locations Name Address Panel.

DXC will utilize Decision Support System (DSS) to create listings of fax numbers, email addresses and mailing addresses based on the bulletin address preferred by the provider.

3.4 CLIA UPDATES

The Clinical Laboratory Improvement Act (CLIA) sets guidelines for the payment of laboratory services. Beginning June 1, 1998, all claims containing laboratory codes are subject to CLIA editing. To be paid for laboratory CPT codes, providers must have a current CLIA number on file that is in force for the dates of service.

If there is no CLIA number on file for a specific provider location, or if there is a CLIA number on file and the line item date of service is not within the CLIA certification dates, the laboratory line item will deny with Explanation of Payment (EOP) code 4207 (CLIA number not on file/invalid or provider not authorized to bill procedure code) .Also if the laboratory certification is either Waived Test or Physician Performed Microscopy Procedure (PPMP), they are restricted to specific codes. If any other laboratory codes are billed, those line items will deny with EOP code 4207 as well.

The Provider Enrollment specialists add CLIA information to the provider file using the Provider CLIA Maintenance Panel.

1. Providers send in CLIA certification information to Provider Enrollment through one of the following methods:

Sending a letter requesting that the CLIA information is added/changed.

Including the information in the original Provider Enrollment application.

Note: A copy of the CLIA certification must accompany all requests to add or change CLIA information.

2. The Provider Enrollment specialist updates the CLIA information on the AMMIS by accessing the Provider CLIA Maintenance Panel and adding the 10 digit CLIA number to the appropriate NPI.

3. CLIA information on the AMMIS is systematically verified against the Centers for Medicare and Medicaid Services (CMS) OSCAR file, which contains all valid CLIA certification information. The verification is completed as follows:
    a. Each Thursday night, a job is run that validates the CLIA information on the AMMIS against the CMS OSCAR file.
    b. CLIA information on the AMMIS that is validated against the CMS OSCAR file is automatically added to the Provider CLIA Maintenance Panel. The information contained on the Provider CLIA Maintenance Panel is used in claims processing.

CLIA certification which is added to the provider file will receive the effective date of the enrollment.

3.5 DISCLOSURE INFORMATION

1. Disclosure information on the web portal application must be completed if the applicant is an individual or an individual within a group. If the applicant is enrolling as a group or a facility, disclosure forms for each individual that is an owner, officer, agent, directors, managing employees, or shareholders with 5% or more controlling interest must be completed.
2. Disclosure information on the web portal application or the paper form requires all questions be answered. Each question must contain a 'yes' or 'no' answer. If the form does contain blanks, return the application to the provider.
3. If any disclosure questions on the web portal application or if the paper form contains any 'yes' answers or no answers with qualifying statements, forward the application to the Program Integrity Division of Medicaid.
4. Update the Feith workflow to document the action of forwarding the application to Program Integrity Division at the Medicaid Agency.
5. Send a letter to the provider, stating that the application has been sent to Medicaid for review and is in a pending status.
6. The Provider Enrollment supervisor will monitor all applications forwarded to Program Integrity Division.

3.6 NAME CHANGES

All name changes must be submitted on the Name Change Form or a written, signed request from the provider.

3.7 LICENSURE VERIFICATION

In-State Providers

It is essential that enrolled providers be licensed to practice medicine in the State of Alabama. To ensure that this is the case, DXC performs, at a minimum, an annual licensure verification process. The following steps are performed to complete the licensure verification process for instate providers:

1. Receive licensure file information from each of the licensure boards, at least annually, via electronic media or hard copy. The table below shows the licensure board and file delivery dates:

Licensure Boards

Licensure Board	Licensure Expiration Date	Data Set Member	Medium
Audiology/Speech Therapy	12/31	SPEECH	Paper
Chiropractor	09/30	CHIRO	Paper
Dental	12/31	DENTISTS	Paper
Medical	12/31	DOCS	Electronic
Nursing	12/31	NURSE	Electronic
Occupational Therapy	04/30	OCTHERPY	Paper
Optometry	12/31	OPTOM	Paper
Physical Therapy	10/01	PHTHERPY	Paper
Podiatry	11/15	PODIATRY	Paper
Psychology	10/15	PSYCHO	Paper
Behavior Analyst	12/31	Behavior Analyst	Paper/Electonic

2. DXC accepts licensure file information in one of two formats: electronic or paper. See the table above for the applicable medium.

Upon receipt, each roster will be saved as a comma delimited file and transmitted to the UNIX server, where an "on request" job will process all rosters. To allow for rosters received (or processed) late, a job parameter will accept a date to be used as the basis for determining expired licenses. If no date is entered, the run date will be assumed.

Roster-specific steps will extract the license number, transfer it into the appropriate database format, and capture or derive the license expiration date. A final step (common to all rosters) will search for each of these license numbers on the “T_PR_HB_LIC” table. If an entry is found with an active status, and an expiration date no older than one year (current for out of state), the expiration date will be updated.

The "T_PR_TYPE" table will then be searched to find all provider locations associated with the license number. Finally, the "T_PR_PHP_ELIG" table is searched for these locations. If an entry is found with an active status, and an expiration date no older than one year (current for out of state), the expiration date will be updated.

This process will neither add new records to the database, nor modify any data fields other than expiration date.

3.7.1 Out-of-State Bordering Providers

Systematic updates are not applicable. Out of state bordering providers' files are updated as requested by the provider. Provider Enrollment will perform on-line license verification to confirm the provider's license has not expired and that there are no current limitations on the license.

3.7.2 Out-of-State Non-Bordering Providers

Systematic updates are not applicable. Out of state non-bordering providers' files are updated as requested by the provider. Provider Enrollment will perform on-line license verification to confirm the provider's license has not expired and that there are no current limitations on the license.

3.8 CHANGE OF OWNERSHIP

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy.

Procedures Following a Change in Ownership

Institutions are to notify Medicaid of any CHOW or closure as soon as Medicare has been notified. The new owner has an option to accept assignment of the existing Medicaid Provider agreement or to reject it as outlined below:

Accept previous Owner's Medicaid Agreement results in:

- Uninterrupted participation in Medicaid
- Uninterrupted Medicaid reimbursement for claims by utilizing the previous owner's Medicaid ID number
- New owner subjected to any liabilities such as overpayments to the previous owner and any adjustment of payment
- The new owner must complete and submit a Change of Ownership form, a new Electronic Funds Transmittal Form (EFT), W-9, Civil Rights Compliance Information Request Package, and Disclosure Forms. Disclosure Forms must be completed for any new owners, officers, directors, agents, managing employees, and shareholders with 5% or more controlling interest. These required forms are located on the Medicaid website.
- New owner completing the CHOW form instead of completing a new enrollment application.

Reject Previous Owner's Medicaid Agreement results in:

- Interrupted participation in Medicaid
- Contract terminated effective the date of acquisition
- The new owner's Medicaid contract will be effective the date of Medicare compliance
- The effective date for claims reimbursement not being retroactive to the date of acquisition

Acquisition followed by combination into one institution:

- If the previous owner's agreement is accepted by the new owner, the acquired institution becomes a remote location or second campus.
- If the previous owner's agreement is rejected by the new owner, the second location must undergo a full Medicare survey.

3.9 PROVIDER FILE CLOSURES

Provider files should be closed accordingly if either of the below situations are encountered or Agency requests are received for file closures. Batch processes have been created to assist in facilitating these changes; however, staff should ensure the closures are completed.

1. When a group provider number and its contracts are closed for any purpose, close all contracts assigned to any individual provider number associated with that group. Close any EFT segments associated with these providers.
2. When all associated individual provider numbers within a group and their assigned contracts are closed for any purpose, close the group number and its contracts. Close any EFT segments associated with these providers.

4 PROVIDER ENROLLMENT INSTRUCTIONS

4.1 GENERAL INSTRUCTIONS

All potential providers will be required to submit a completed electronic enrollment application. In addition to the completed application, the provider must complete the following items before an application can be considered approved:

Signed Alabama Medicaid Provider Agreement

Disclosure of Ownership and Control Interest Statement

IRS W9 form

Electronic Funds Transfer Authorization Agreement for facility, group enrollments and individual providers who are not associated with a group.

After a completed application is approved, the approval letter will be sent to the provider.

If a provider changes the provider address, a letter must be sent to Provider Services to notify the unit of the new address information.

Provider instructions provided in this section are for the following provider types:

Ambulatory Surgical Center (ASC)

Audiologist

CRNA (Advanced Practice Nurse)

Dentist

Durable Medical Equipment

EPSDT

EPSDT Referrals & QMB/EPSDT

Federally Qualified Health Centers (FQHC)

Hearing Aid Dealer

Home Health

Hospice

Hospital

Independent Laboratory

Independent Nurse Practitioner (Advanced Practice Nurse)

Independent Radiology

Independent Rural Health Clinic

Licensed Social Worker

Lithotripsy (ESWL)

Nursing Home

Nurse Midwife

Off-Site EPSDT

Optician

Optometrist

Patient 1st Enrollment Procedures

Pharmacy

Physician

Physician Employed Nurse Practitioner (Advanced Practice Nurse)

Physician Employed Physician Assistant

Physiological Lab

Plan 1st Enrollment Procedures

Post Extended Care (PEC) Provider

Prenatal Education

Preventive Health Education

Private Duty Nursing

Provider Based Rural Health Clinic

Psych Hospital Over 65

Psych Hospital Under 21

Rehab Hospital

End-Stage Renal Disease (RSD) Clinic

State Agencies

Swing Bed Hospital

Transportation

4.1.1 Ambulatory Surgical Center (ASC)

Type

02

Specialty

020 ASC

520 Lithotripsy (see Lithotripsy section of this manual for details)

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated for all instate and out-of-state bordering ASC facilities:

- Verify Medicare certification in PECOS.
- Copy of the current Hospital Transfer Agreement to a hospital that accepts Alabama Medicaid patients.
- Evidence that all physicians utilizing the Ambulatory Surgical Center (ASC) will accept Alabama Medicaid patients.
- Copy of the current state license.
- A Certification and Transmittal (C&T) has to be received from the Department of Public Health notifying DXC that the facility is certified. (for instate facilities only)
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

The effective date of enrollment will be the Medicare enrollment effective date due to the Medicare certification being a requirement.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. A C&T must be received from the Department of Public Health notifying DXC that ownership has changed. See detailed CHOW policy under Section 3.8.

Name Change

Use the Name Change form or a written request from the provider and attach a W-9 form. A Certification and Transmittal must be received from the Department of Public Health notifying DXC that the name has changed.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

Change of Service Location Address

The Department of Public Health (DPH) will notify DXC that the center has had a change of address. DXC may change the provider's address using the C&T from DPH.

All other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

With the exception of requiring a C&T, out-of-state non-bordering providers are enrolled for the date(s) of service only following the in-state enrollment procedures.

NOTE:

Out-of-state ASC providers may submit the one page Out-of-State ASC/Hospital Update Form in order to extend the enrollment period for either number assigned. This form is only acceptable if the ASC file did not expire more than one year prior to the submission date of the form. If the file has been expired for more than one year, an application must be processed.

4.1.2 Audiologist

Type

20

Specialty

200 Audiologist

930 School Based Audiologist (See instructions under Local Education Agency)

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Provider Enrollment will perform an on-line verification to confirm that the Audiologist's license has not expired.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

NOTE:

If a provider has more than one location, each location must be enrolled separately.

The effective date of enrollment will be the first day of the month in which the request for enrollment was received or the Medicare enrollment effective date. In no event will the Medicaid effective date be prior to the issue date of the professional license. Enrollment stop date will be the expiration date of the professional license with a 45-day grace period.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, and Provider EFT Account panels.

Provider enrollment procedures no longer require that individual providers enroll with Medicare prior to applying to Medicaid. This is due to the often-lengthy enrollment process with Medicare. Providers will be given the option on the enrollment application to enroll with Medicaid prior to being approved to participate with Medicare.

OPTION 1

If the provider chooses to enroll with Medicaid before Medicare, we enroll the provider using the enrollment process currently used for a Pediatrician. This includes ensuring the application is complete and verifying the license information with the appropriate license board. The effective date of enrollment will be the first day of the month in which the application is received.

OPTION 2

If the provider has already been approved to participate in the Medicare program, the effective date of enrollment will be the Medicare effective date. Medicare certification can be verified in PECOS. This documentation is then used in lieu of contacting

Medicare to verify the provider's Medicare information. Obtaining this information will improve enrollment and produce more accurate tax information for 1099 reporting.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee Name Change and Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Out of state non-bordering providers are enrolled for the date of service only.

4.1.3 CRNA (Advanced Practice Nurse)

Type

09

Specialty

094 CRNA (Certified Registered Nurse Anesthetist)

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Copy of current certification with the Alabama Board of Medical Examiners Certification Registration.
- DXC enrollment staff must perform on-line verification of the Certified Registered Nurse Anesthetist license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

NOTE:

If a provider has more than one location, each location must be enrolled separately.

The effective date of enrollment will be the first day of the month in which the request for enrollment was received or the Medicare enrollment effective date. In no event will the Medicaid effective date be prior to the issue date of the professional Registered Nurse's license. Enrollment stop date will be the expiration date of the professional Registered Nurse's license with a 45-day grace period.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, and Provider EFT Account panels.

Provider enrollment procedures no longer require that individual providers enroll with Medicare prior to applying to Medicaid. This is due to the often-lengthy enrollment process with Medicare. Providers will be given the option on the enrollment application to enroll with Medicaid prior to being approved to participate with Medicare.

OPTION 1

If the provider chooses to enroll with Medicaid before Medicare, we enroll the provider using the enrollment process currently used for a Pediatrician. This includes ensuring the application is complete and verifying the license information with the appropriate license board. The effective date of enrollment will be the first day of the month in which the application is received.

OPTION 2

If the provider has already been approved to participate in the Medicare program, the effective date of enrollment will be the Medicare effective date. Medicare certification can be verified in PECOS. We can then use this documentation in lieu of contacting Medicare to verify the provider's Medicare information. Obtaining this information will improve enrollment and produce more accurate tax information for 1099 reporting.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Effective date will be the date of service.

4.1.4 Dentist

Type

27

Specialty

271 General Dentistry Practitioner

275 Endodontist

276 Pediatric Dentistry

277 Orthodontist

278 Periodontist

299 Mobile Provider

311 Anesthesiology – (Must submit a copy of their IV Sedation Certification).

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Copy of IV sedation certification, if provider intends to perform IV sedation procedures.
- Copy of DEA Certificate.
- Copy of mobile dental facilities or portable dental operations certificate.
- DXC enrollment staff must perform on-line verification of the dentist license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

NOTE:

If a provider has more than one location, each location must be enrolled separately.

The effective date of enrollment will be the first day of the month, in which request for enrollment was received by DXC. The Medicare enrollment effective date will be utilized if the provider has been approved by Medicare. In no event will the Medicaid effective date be prior to the issue date of the professional license. Enrollment stop date will be the expiration date of the professional license with a 45-day grace period.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, and Provider EFT Account panels.

Provider enrollment procedures no longer require that individual providers enroll with Medicare prior to applying to Medicaid. This is due to the often-lengthy enrollment process with Medicare. Providers will be given the option on the enrollment application to enroll with Medicaid prior to being approved to participate with Medicare.

OPTION 1

If the provider chooses to enroll with Medicaid before Medicare, we enroll the provider using the enrollment process currently used for a Pediatrician. This includes ensuring the application is complete and verifying the license information with the appropriate license board. The effective date of enrollment will be the first day of the month in which the application is received.

OPTION 2

If the provider has already been approved to participate in the Medicare program, the effective date of enrollment will be the Medicare effective date Medicare certification can be verified in PECOS. We can then use this documentation in lieu of contacting Medicare to verify the provider's Medicare information. Obtaining this information will improve enrollment and produce more accurate tax information for 1099 reporting.

Adding Specialty 299

Providers who are currently enrolled as a Medicaid dental provider must submit a letter requesting that specialty 299 (mobile provider) be added to their file. A copy of the mobile dental facilities or portable dental operations certificate issued by the Board of Dental Examiners must also be submitted. The effective date will be the first of the month in which the request/certification is received.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Address Change

Also update the address on Provider Information Panel.

Out-of-State Non-Bordering Providers

Effective date will be the date of service.

4.1.5 Durable Medical Equipment (DME)

Type

25

Specialty

250 DME/Medical Supply Dealer

251 Prosthetic and Orthotic Provider (Only added if Agency Directs)

254 Mastectomy Fitter

256 Therapeutic Shoe Fitter

NOTE:

Prior to enrollment, DME applications should be forwarded to the DXC Provider Representative for onsite inspections and they will approve the enrollments of DME providers if they meet the requirements. **THE PROVIDER SHOULD NOT BE INFORMED THAT A VISIT WILL BE MADE.**

Program Integrity should only receive applications if there are Disclosure issues or the application is from an out of state provider applicant.

Please forward all governmental agency applications to the Program Integrity Division for approval. If a DME supplier does not have a business license, it may be a governmental agency DO NOT ENROLL.

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Provider must be certified to participate as a Medicare provider. A provider's Medicare enrollment must be verified in PECOS. Do not ask for the Medicare certification letter.
- A copy of a valid license from the Alabama Board of Home Medical Equipment Services Providers, when applicable.
- Be certified to participate as a Medicare provider.
- Medicare Accreditation
- Medicare Surety Bond
- Medicaid Surety Bond (See Medicaid surety bond information below)
- A valid business license
- The provider shall have no felony convictions and no record of willful or grossly negligent noncompliance with Medicaid or Medicare regulations.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

Specialty Name	Specialty Number	Type of Operations	License/ Certification Required	License/Accreditation Board Website
DME	250	DME only A, B, E, S, T HCPCS codes	HME license	Alabama Board of Home Medical Equipment (HME) Service Providers www.homemed.alabama.gov
Prosthetic, Orthotics & Prosthesis **(POP/YPOP)**	251	Prosthetic, Orthotic & Pedorthic (POP) Services only custom fabricated devices only	O&P facility license	Alabama State Board of Prosthetists and Orthotists www.apob.alabama.gov
Mastectomy Fitter (MSFIT)	254	Mastectomy Fitters "L" HCPCS codes (specified)	******Mastectomy Fitter (MSF) license	Alabama State Board of Prosthetists and Orthotists www.apob.alabama.gov
		HME providers using prefabricated or off-the-shelf orthoses "L" HCPCS codes	MSF **and** HME licenses	
Therapeutic Shoe Fitter (TSFIT)	256	Therapeutic Shoe Fitters "A" HCPCS codes	******Therapeutic Shoe Fitter (TSF) license	Alabama State Board of Prosthetists and Orthotists www.apob.alabama.gov

Medicaid Surety Bond Requirements

Effective October 1, 2010, all DME providers must have a $50,000.00 Medicaid Surety Bond for each store location. A DME and medical supply business is exempt from the Medicaid Surety Bond requirements if the DME and medical supply business:

- Is a DME supplier who has been a Medicaid provider for five years or longer with no record of impropriety, and whose refund requests have been repaid as requested; or
- Is a government-operated Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). DME suppliers who provide Breast Prosthesis, Diabetic Shoes and Diabetic Shoe Inserts are not included in this exemption
- Is a state-licensed orthotic and prosthetic personnel in private practice making custom-made orthotics and prosthetics; or
- Are physicians and non-physician practitioners, as defined in section 1842(b)(18) of the Social Security Act; or
- Are Physical and Occupational Therapists in private practice; or
- Are providers who received $100,000 or less Medicaid payment in the past two calendar years, and have been operating at this same location for at least two consecutive calendar years; or
- Are pharmacy providers; or
- Are phototherapy providers who only provide phototherapy services for infants; or
- Are Federally Qualified Health Centers.

Prosthetic, Orthotic and Pedorthic Providers

The providers of Prosthetic, Orthotic, and Pedorthic devices for adults age 21 – 64 and youth age 0 – 20, must be licensed by the Alabama Board of Prosthetics, Orthotics and Pedorthics. Prosthetic and Orthotic providers should be enrolled with specialty 251.

Applicable to In-State DME providers ONLY. Medicaid does not enroll out of state DME POP providers.

Approval to add specialty 251 is given by the Alabama Medicaid Agency. Applications should be forwarded to the Program Integrity Division, Enrollment and Sanctions Unit via Workflows for review. However, if the application is denied, then it can be forwarded to the DXC Provider Representative for a site visit if they request to be a DME provider.

Providers of Prosthetic, Orthotic, and Pedorthic devices must meet the following requirements which includes the requirements for Durable Medical Equipment providers.

- Licensed by the Alabama Board of Prosthetics, Orthotics, and Pedorthics
- Instate provider ONLY
- Medicare certification must be verified in PECOS.
- Medicare Surety Bond

- Medicare Accreditation
- Medicaid Surety Bond
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

Alabama Board of Home Medical Equipment Services License Exemption

The following entities or practitioners are exempted from receiving a license from the Alabama Board of Home Medical Equipment Services

- Home Health agencies certified by the State of Alabama to participate in the Medicare and Medicaid programs.
- Hospital based home medical equipment services, whether or not the services are provided through a separate corporation or other business entity.
- Health care practitioners legally eligible to order or prescribe home medical equipment, or who use home medical equipment to treat patients in locations other than the patient's residence.
- Manufacturers and wholesale distributors, when not selling directly to a patient.
- Retail community pharmacies, including providers of home infusion therapy services.
- Hospice programs, except programs which provide home medical equipment services, including delivery to a patient's residence.
- Skilled nursing facilities, except facilities which provide home medical equipment services, including delivery to a patient's residence.
- Governmental agencies, including fire districts which provide emergency medical services and contractors to governmental agencies whose business deals only with the contracted agency.
- Mail order companies, if deliveries are made only via common carriers, including the United States Postal Service.

Medicare Accreditation Exemptions

The following providers are exempted from the Medicare Accreditation:

- Suppliers providing drugs and pharmaceuticals ONLY
- Physicians (including Dentists)
- Audiologists
- Optometrists
- Orthotists
- Prosthetists (including Ocularists)
- Prosthetists are not exempt from Medicare Accreditation if they provide durable medical equipment, breast prosthesis, diabetic shoes and diabetic shoe inserts.
- Opticians

- Occupational Therapists
- Physical Therapists

NOTE:

Pharmacy providers are required to be Medicare certified which can be verified in PECOS. Pharmacy providers are not required to submit a Medicare Surety Bond, Medicare Accreditation nor a Medicaid Surety Bond.

DXC will enter the Medicare Surety Bond number, Medicare Surety Bond and Medicare Accreditation dates in interchange. The end date will remain one year from the effective date. If Surety Bond does not show an effective date, the signature date may be used as the effective date for the Bond.

DXC will receive Medicaid Surety Bonds from DME providers. DXC will enter the bond number. The effective date for the Medicaid Surety Bond is the date on the bond. The bond end date is one year from the effective date.

New providers are required to have a Medicare Surety Bond, Medicare Accreditation, and Medicaid Surety Bond. DXC should not accept any bonds that are not complete. All required information should be completed on the bond.

Some bonds are continuous until cancelled by the Surety. The provider will submit the yearly renewal receipt to DXC.

The effective date of enrollment will be the Medicare enrollment effective date due to the Medicare certification being a requirement. However, if a provider's request for enrollment is received more than 120 days after the date of their Medicare certification, then the effective date will be the first day of the month the enrollment is initially received by DXC.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

NOTE:

Newly enrolling DMEs are always assigned an initial risk screening level of high and must have a fingerprint based criminal background check (FCBC) completed for anyone with 5% or more ownership.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. See detailed CHOW policy under Section 3.8.

Name Change

Use the Name Change form or a written, signed request from the provider and attach a W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

NOTE:

If the DME supplier has a new Tax Id number, the DME supplier will be required to complete a new provider enrollment application.

All providers with questions regarding state licensure should be referred to the Alabama Board of Home Medical Equipment Services Providers at (334) 215-3474. DXC should return any application if the license from the board is not enclosed with the application.

The specialty 590 (TA Waiver) can be added to the DME provider file. Medicaid will forward a memo to DXC indicating to add the 590 specialty to the file. The provider does not need to complete the TA Waiver Amendment.

Physicians may enroll with an individual Medicare certification or the group Medicare certification. Medicare certification can be verified in PECOS.

Effective January 1, 2011, Medicaid will accept a copy of the renewal receipt for Medicare and Medicaid Surety Bonds. DME providers must renew their bond each year with the Surety Bond Company. Durable Medical providers have the following language in their Medicare and Medicaid Surety Bonds. "The term of the bond shall be from the ___day of ___,____and shall be continuous until cancelled by the Surety." If the Surety Bonds does not include the language above, the Surety Bond renewal receipt will not be allowed.

Effective June 5, 2015, out-of-state providers of home medical equipment and services provided in accordance with state or federal law or regulation to Alabama Medicaid recipients are exempt from the HME law.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and signed.

A W-9 tax form is required if there is a change in the physical address and a site visit must be completed.

All other out-of-state providers are **only** eligible for crossover claims, use current out-of-state enrollment application. Crossover Only providers should be given the “QMB Only” contract only.

If a bordering DME provider is crossover only and would like to change to an “active” provider, a new application must be submitted with all required documentation and follow normal enrollment guidelines to include a site visit.

4.1.6 Out-of-State Non-Bordering Providers

Type

25

Specialty

250 DME/Medical Supply Dealer

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated for out-of-state non-bordering DME suppliers:

- Copy of current state license, if applicable.
- Medicare Surety Bond
- Copy of DMERC notification from Medicare.
- Medicare Accreditation verified in PECOS.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

NOTE:

If provider states they are an out-of-state mail order, the provider may enroll as a crossover provider.

To enroll as an out-of-state DME, the provider must have a physical location and a business license. If the provider does not have a business license, due to the state not requiring a business license, the provider must submit written information from the state licensing agency.

All Out-of-State Non-Bordering DME applications should be forwarded to the Agency (Program Integrity Division) for approval before enrolling.

DME Providers of Prosthetic, Orthotic, and Pedorthic devices must be licensed by the Alabama Board of Prosthetics, Orthotics and Pedorthics; be an In-State DME provider ONLY, and meet the same requirements as Durable Medical Equipment (DME) providers.

If a provider has more than one location, each location must be enrolled.

Effective date of enrollment will be the date of service. Enrollment stop date will be open-ended.

Other enrollment guidelines are the same as for in-state providers.

NOTE:

Set provider status to ‘X’-over. Out-of-state non-bordering DME providers should be given the QMB Only contract.

Site Visits

Required to have a site visit completed during initial enrollment and reenrollment.

If the application is for an out-of-state non-bordering provider requiring a visit and a Medicare visit was not verified, the associated state Medicaid Agency should be contacted to determine if a visit was conducted using provided contact information from the Alabama Medicaid Agency. Document the visit by putting the individual contacted and site visit date in the notes in Feith. If this cannot be verified, the DME

can be enrolled by verifying the Medicare certification in PECOS to satisfy the site visit requirement.

4.1.7 End-Stage Renal Disease (ESRD) Clinic

Type

30

Specialty

300 Free-Standing Renal Dialysis Clinic

324 Nephrologist

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated.

- Verify Medicare certification in PECOS.
- Copy of their state license.
- A C&T must be received from the Department of Public Health. When the C&T and current state license is received, the application can be approved for enrollment.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

The effective date of enrollment will be the effective date of the Medicare certification.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. A C&T must be received from the Alabama Department of Public Health before changes can be made to the provider file. See detailed CHOW policy under Section 3.8.

Name Change

A C&T must be received from the Alabama Department of Public Health. On receiving the C&T, send the provider a name change form, EFT Authorization Agreement form and a W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

If a renal dialysis facility has a change of address, DXC will receive a C&T from the Department of Public Health. The provider may notify DXC in writing by fax or e-mail. DXC will make this change due to the risk of returned mail or denied claims, etc. Contact the Deputy Director of the Division of Provider Services at the Department of Public Health at 206-5591 to make sure that the facility has notified him. All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Date of enrollment will be the dates of service.

4.1.8 EPSDT

Type

31 Physician

58 Rural Health

13 Public Health Agency (Refer to State Agency Instructions)

56 FQHC

09 Independent Nurse Practitioner (Advanced Practice Nurse)

Physician Employed Practitioner (Advanced Practice Nurse)

Specialty

820 Referring Provider Only (Not a screening provider but can refer patients)

560 EPSDT

Additional Approval

Upon initial enrollment the EPSDT Agreement provided on the Medicaid Agency website and current CLIA certificate should be submitted.

If opting to enroll as an EPSDT screener after initial enrollment, the EPSDT Agreement provided on the Medicaid Agency website should be completed.

The effective date of enrollment, for currently enrolled providers, is the first day of the month that the completed EPSDT Agreement is received in the Provider Enrollment department. Effective date of enrollment for new providers is the same date as the Medicaid effective date.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

NOTE:

When processing an EPSDT Agreement, check the Provider Contract Panel for an active EPSDT specialty code. Check the Provider CLIA Maintenance Panel for an active CLIA number. If specialty code 560 is already present and an active CLIA number is on file, notify the provider of the EPSDT effective date.

If specialty code 820 is on file, which is the Patient 1st non-screening PMP specialty, the 820 should be end dated with a date sequential to the begin date of the 560 specialty. (This end date should be the day before the start date of the 560 specialty).

4.1.9 EPSDT Referrals & QMB/EPSDT

Type

15 Chiropractor

17 Therapist

14 Podiatrist

54 Psychologist

07 Behavioral Health

Specialty

150 Chiropractic

140 Podiatrist

173 Speech/Hearing Therapist

170 Physical Therapist

171 Occupational Therapist

112 Psychologist

600 QMB/EPSDT

070 Licensed Professional Counselor (LPC)

071 Associate Licensed Counselor (ALC)

072 Licensed Marriage and Family Therapist (LMFT)

073 Licensed Master Social Worker (LMSW)

074 Licensed Independent Clinical Social Worker (LICSW)

175 ABA Therapist

NOTE:

Specialty 600 is required for all of the above listed provider types. Hospital employed therapists are not eligible to enroll in the Alabama Medicaid Program.

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

Chiropractor – (QMB/EPSDT)

- Medicare certification verified in PECOS (for QMB).
- DXC enrollment staff must perform on-line verification of the Chiropractor license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Occupational Therapy – (QMB/EPSDT)

- Medicare certification verified in PECOS (for QMB).
- DXC enrollment staff must perform on-line verification of the Occupational Therapy license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Physical Therapy – (QMB/EPSDT)

- Medicare certification verified in PECOS (for QMB).
- DXC enrollment staff must perform on-line verification of the Physical Therapy license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Podiatrists – (QMB/EPSDT)

- Medicare certification verified in PECOS (for QMB).
- DXC enrollment staff must perform on-line verification of the Podiatrists license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Psychologists – (QMB/EPSDT)

- Medicare certification verified in PECOS (for QMB).
- DXC enrollment staff must perform on-line verification of the Psychologist license to confirm that the provider's license has not expired and that there are

no current limitations on the provider's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD.

- Possess a doctoral degree from an accredited school or department of Psychology.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Speech Therapy – (QMB/EPSDT)

- Certificate of Clinical Competence (CCC).
- DXC enrollment staff must perform on-line verification of the Speech Therapy license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD.
- Medicare certification verified in PECOS (for QMB).
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Licensed Professional Counselor (LPC) / Associate Licensed Counselor (ALC) – (EPSDT)

- DXC enrollment staff must perform on-line verification of the LPC or ALC license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD.
- Possess a master's degree or above from an accredited school.
- Submit completed Civil Rights Compliance Information Request Package.

Licensed Marriage and Family Therapist (LMFT) – (EPSDT)

- DXC enrollment staff must perform on-line verification of the LMFT license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD.
- Possess a master's degree or above from an accredited school.
- Submit completed Civil Rights Compliance Information Request Package.

Licensed Master Social Worker (LMSW) / Licensed Independent Clinical Social Worker (LICSW) – (QMB/EPSDT)

- Medicare certification verified in PECOS (for QMB)
- DXC enrollment staff must perform on-line verification of the LMSW or LICSW license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD.
- Possess a master's degree or above from an accredited school.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Board Certified Behavior Analyst – ABA Therapy – (EPSDT)

- DXC enrollment staff must verify license with the Alabama Behavior Licensing Board to confirm that the provider's license has not expired and that there are no current limitations on the provider's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD.
- Submit completed Civil Rights Compliance Information Request Package.

NOTE:

If a provider has more than one location, each location must be enrolled separately.

The effective date of enrollment will be the first day of the month in which the request for enrollment is received by DXC or the Medicare enrollment effective date. In no event will the Medicaid effective date be prior to the issue date of the professional license. Enrollment stop date will be the expiration date of the professional license with a 45-day grace period.

Provider enrollment procedures no longer require that individual providers enroll with Medicare prior to applying to Medicaid. This is due to the often-lengthy enrollment process with Medicare. Providers will be given the option on the enrollment application to enroll with Medicaid prior to being approved to participate with Medicare.

OPTION 1

If the provider chooses to enroll with Medicaid before Medicare, we enroll the provider using the enrollment process currently used for a Pediatrician. This includes ensuring the application is complete and verifying the license information with the appropriate license board. The effective date of enrollment will be the first day of the month in which the application is received.

OPTION 2

If the provider has already been approved to participate in the Medicare program, the effective date of enrollment will be the Medicare effective date. Medicare certification can be verified in PECOS. We can then use this documentation in lieu of contacting Medicare to verify the provider's Medicare information. Obtaining this information will improve enrollment and produce more accurate tax information for 1099 reporting.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and signed.

Out-of-State Providers

Medicare certification is not necessary. Start date will be the date of service.

Site Visits

Licensed Professional Counselor (LPC), Associate Licensed Counselor (ALC), Licensed Marriage and Family Therapist (LMFT), Licensed Master Social Worker (LMSW), Licensed Independent Clinical Social Worker (LICSW), and Physical Therapy - Required to have a site visit completed during initial enrollment and reenrollment.

4.1.10 Federally Qualified Health Centers (FQHC)

Type

56

Specialty

021	Cardiac Electrophysiology		
023	Sports Medicine		
080	FQHC - Required Specialty	328	Obstetrician/Gynecologist
093	Nurse Practitioner (Other)	329	Oncologist
095	Certified Nurse Midwives	330	Opthamologist
100	Physician's Assistant	331	Orthopedic Surgeon
112	Psychologist		
116	Licensed Social Worker	332	Otologist,Larynologist,Rhinologist
140	*Podiatrist	333	Pathologist
150	*Chiropractor	336	Physical Medicine & Rehab Pract
180	Optometrist	337	Plastic Surgeon
271	General Dentist Practitioner	338	Proctologist
272	Oral Surgeon	339	Psychiatrist
299	Mobile Provider (Cert from Dental Board Required)	340	Pulmonary Disease Specialist
310	Allergist	342	Thoracic Surgeon
311	Anesthesiologist	343	Urologist
312	Cardiologist	345	General Pediatrician
313	Cardiovascular Surgeon	560	EPSDT
314	Dermatologist	600	*QMB/EPSDT – Required for 140/150
315	Emergency Medicine	750	Colon and Rectal Surgery
316	Family Practitioner	770	Endocrinology
317	Gastroenterologist	780	Hematology
318	General Practitioner	790	Infectious Disease
319	General Surgeon	800	Internal Medicine
320	Geriatric Practitioner	810	Orthopedic
321	Hand Surgeon	830	Rheumatology
323	Neonatologist	911	SBIRT – Effective 1/1/2010
324	Nephrologist	931	Telemedicine Services
325	Neurological Surgeon		
274	Dental Prevention		

Additional Approval

Applicant must provide the following if the FQHC is enrolling for the first time:

- Copy of Grant Award Notice from the Public Health Services that grants permission to operate in Alabama.
- Medicare certification verified in PECOS, if applicable.
- Copy of CLIA certification.
- Copy of IV Sedation Certification if provider intends to perform IV Sedation procedures.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.
- Budgeted cost report.
- List of all satellite clinics and addresses.
- Enrollment applications for all physicians, nurse midwives, nurse practitioners, physician assistants, dentists, licensed social workers, chiropractors and podiatrists who are employed by the FQHC and the satellite clinics where they are assigned.
- In order to add the 911 specialty, Provider Enrollment will receive a memo from the state to add this specialty to the provider's file.
- Chiropractors Medicare certification must be verified in PECOS.
- Podiatrists Medicare certification must be verified in PECOS.
- All physicians with an Alabama license, enrolled as a provider with the Alabama Medicaid Agency, regardless of location, are eligible to participate in the Telemedicine Program to provide medically necessary telemedicine services to Alabama Medicaid eligible recipients. In order to add the 931 Telemedicine Services specialty, the provider must submit the Telemedicine Services Agreement/Certification form. As stated on the Agreement/Certification form, Enrollment staff must ensure that a **sample copy** of the Provider's Informed Consent form is attached to this agreement. A sample copy has been provided for Enrollment staff. Enrollment staff must review the submitted Provider's Informed Consent form to ensure that it contains the information that is in the Agency's sample copy.
- In order to add the 274 specialty, the provider should submit a written request along with their certificate of completion. DXC enrollment staff will verify providers completion of the 1st Look training by checking the list provided by ALAAP. Note: This specialty should not be a primary specialty.

Send budgeted cost report to Provider Audit who determines the rate. Enrollment is not complete until this rate has been received and added to the customary charge panel.

NOTE:

Individuals who are being added to an existing FQHC will be assigned the encounter rate, found on the customary charge panel of the existing group.

Forward notification of any newly established FQHC payees to Clinic Services, Medical Services Division, Medicaid, and to the current provider representative for the FQHC Program.

The effective date of enrollment will be the first day of the month in which the Medicaid enrollment application was received and the termination date will be 60 days beyond the end date of the budget period indicated on the Grant Award Notice.

> An updated Grant Award Notice must be sent in annually in order to extend enrollment.

The FQHC must notify DXC in writing when they add a new satellite clinic. The following information must be provided:

- Copy of Health Resources Services Administration (HRSA) Notification showing that the new satellite is approved.
- A completed enrollment application.
- Completed enrollment application for each health care professional at the satellite clinic.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. See detailed CHOW policy under Section 3.8.

Name Change

Use the Name Change form or a written, signed request and attach a W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Bordering Providers

Federally Qualified Health Centers that are no more than 30 miles from the Alabama border are eligible to participate in the Alabama Medicaid Program as long as the bordering FQHC meets all the requirements of an in-state FQHC and has permission in the Grant Award Notice to operate in Alabama.

Reimbursement for an enrolled out-of-state FQHC will be the lesser of the encounter rate established by the Medicaid Department of the out-of-state FQHC or the average encounter rate established by the Alabama Medicaid for in-state facilities.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type at this time.

4.1.11 Group/Billing Provider

Type

See enrollment application for type.

Specialty

See enrollment application for specialties.

Additional Approval

- To enroll as a group in the Alabama Medicaid Program, DXC must be supplied with the following:
- A completed enrollment application.
- A completed disclosure form is required for each owner, agent, managing employee, officer, director or shareholder with 5% or more controlling interest that is affiliated with the group. The completed form is to be faxed and mailed to DXC with the bar coded fax cover sheet.
- The Provider Agreement is to be signed and include the authorized person's business title. The signature page is to be faxed and mailed to DXC with the bar coded fax cover sheet.
- The Electronic Funds Transfer Authorization Agreement (EFT) is required.
- Corporations must submit a Certificate of Incorporation for in-state providers. Out-of-State providers must submit a Certificate of Authority to do business in Alabama.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

The effective date of enrollment will be the first day of the month in which, the request for enrollment is received by DXC, if individual providers in the group are not assigned a date prior to the effective date of enrollment. If individual providers associated to the group are assigned an effective date prior to the first of the month the application was received, such as a Medicare certification date, the group/payee provider NPI number should contain the same effective as the earliest date assigned to the individual associated to the group/payee.

***Example**:* Dr. A, who is associated with the group/payee, has a Medicare certification date of January 1, 2003. Dr. B, who is associated with the group/payee, does not have a Medicare certification date, but this provider's application was initially received on February 1, 2003. The group/payee application was initially received on March 1, 2003. Due to the effective date for provider Dr. A being January 1, 2003, which is the earliest date of the provider's enrolling, the group/payee effective should also be January 1, 2003.

The Enrollment stop date will be open ended.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. See detailed CHOW policy under Section 3.8.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing. The request must be signed and include the business title of the person who signs the request and should contain the group/billing provider NPI number.

Out-of-State Non-Bordering Groups

Start date will be the date of service.

4.1.12 Hearing Aid Dealer

Type

22

Specialty

220 Hearing Aid Dealer

Additional Approval

- The applicant must supply their State License to dispense hearing aids. An Audiologist's license can be used in lieu of a Hearing Aid Dealer's license because it is a higher rated license.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

The effective date of the enrollment will be the first day of the month in which the request was received by DXC or issue date of license, whichever is later.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. See detailed CHOW policy under Section 3.8.

Name Change

Use the Name Change form or a written, signed request and attach a W-9 form

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

4.1.13 Home Health

Type

05

Specialty

050 Home Health

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- A certification of meeting the CMS conditions of participation for Home Health Care agencies to participate in the Medicaid program–Certification and Transmittal *(*C&T*)*–has to be received from the Department of Public Health before the enrollment process can begin.
- The C&T must be kept in the provider's file folder.
- It is important to check the following information that is listed on the C&T:
    - #2-Provider NPI Number (for changes).
    - #3-Name and address of the facility.
    - #4 Type of action.
    - #5-Date of Change of Ownership (if the C&T is for a change of ownership). Most times the date of the ownership change is found in item #16.
    - #7-Type Code.
    - #16-Remarks.
- Certificate of Need (CON) or a project exemption for the Home Health Agency.
- After the request and the CON from the provider have been received, send the Home Health Agency an enrollment application.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

The effective date of the Medicaid enrollment is the Medicare effective date indicated on the C&T from Public Health unless Medicaid gives DXC another date for enrollment.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment

- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

NOTE:

Newly enrolling HHAs are always assigned an initial risk screening level of high and must have a fingerprint based criminal background check (FCBC) completed for anyone with 5% or more ownership.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. A C&T must be received from the Department of Public Health notifying DXC that there has been a change of ownership before changes can be made to the provider file. See detailed CHOW policy under Section 3.8.

Name Change

A C&T must be received from the Department of Public Health notifying DXC of the name change before DXC can make changes to the provider file. Use the Name Change form or a written, signed request and attach a W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

NOTE:

Medicaid does not enroll Home Health branch offices and the C & T is filed. Parent offices and sub-units are enrolled.

Address Change

A C&T must be received from the Department of Public Health to change the physical address. DXC will also request a W-9 form and address change update for physical address changes. DXC can change the mailing and payee address without notification from DPH.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

Site Visits

Required to have a site visit completed during initial enrollment and reenrollment. A visit is not required if Medicare completed a site visit within the last 12 months.

Also, Home Health enrollments with specialty 970 (Disease Management) are exempt from a visit.

Hospice

Type

06

Specialty

060 Hospice

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- A certification of meeting the CMS conditions for participation of Hospice Provider agencies to participate in the Medicaid program – the Certification and Transmittal (C&T)–has to be received from the Department of Public Health before the enrollment process can begin.
- Medicare certification verified in PECOS.
- The C&T must be kept in the provider's file folder.
- It is important to check the following information that is listed on the C&T:
    - #2-Provider NPI number (for changes).
    - #3-Name and address of the facility.
    - #4-Type of Action.
    - #5-Date of Change of Ownership (if the C&T is a change of ownership). Most times the date of the ownership change is found in item # 16.
    - #7-Type Code.
    - #16-Remarks.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

The effective date of the Medicaid enrollment is the Medicare effective date indicated on the C&T from Public Health unless Medicaid gives DXC a different enrollment date.

Rates

LTC Provider/Recipient Services Unit will include the hospice rates with the initial for action memo.

Once the steps above are completed, DXC will send the following information to the provider, with an approval letter.

The Alabama Medicaid Hospice Rates notification letter indicates rates that are based on the geographical location of the hospice.

Hospice rates given to DXC by Medicaid.

Notify the LTC Provider/Recipient Services Unit at Medicaid of initial enrollments.

CMS notifies Medicaid each year of the rates for Hospice. After CMS sends the rates, the Medicaid Provider Audit Division calculates a formula for the rates and then provides this formula to the LTC Division for the calculation of the rates. The rates are based on the geographical location of the hospice.

The rates are effective October first of each fiscal year and end December thirty-first of the following calendar year.

In order to find the rates for a particular county, find the Metropolitan Statistical Area (MSA) listed next to the county and refer to the rates for that MSA.

NOTE:

All rural rates are MSA 13.

Do not give Hospice providers the rates for hospice nursing home providers. Nursing home hospice rates are also effective from October first of each fiscal year through December thirty-first of the following calendar year. CMS does not send the rates for nursing home hospices; the Medicaid Provider Audit Division calculates them.

Medicaid will enroll all hospice satellite offices. Enrolling each location will enable Medicaid to distinguish the reimbursement rates for the various hospice locations. Item 1 on the C&T reflects information about the satellite offices to be enrolled.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. A C & T must be received from the Department of Public Health notifying DXC that there has been a change of ownership before changes can be made to the provider file. See detailed CHOW policy under Section 3.8.

Address Change

A C&T must be received from the Department of Public Health to change the physical address. DXC will also request a *W-9* form and address change update for physical address changes. DXC can change the mailing and payee address without notification from DPH.

Name Change

A C&T must be received from the Department of Public Health before name changes can be made to the provider file. Use the Name Change form or a written, signed request.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Providers

Enrollment is not applicable to this provider type.

Site Visits

Required to have a site visit completed during initial enrollment and reenrollment. A visit is not required if Medicare completed a site visit within the last 12 months.

4.1.14 Hospital

Type

01

Specialty

010 Acute Care Hospital

011 Inpatient Psychiatric Hospital over 65

012 Rehabilitation Unit CORE – for crossover claims only

013 Residential Treatment Facility

014 Long Term Care Hospital – for crossover claims only

017 Inpatient Psychiatric Hospital under 21

018 Psych Subpart Enrollment--for crossover claims only

019 Rehab Subpart Enrollment--for crossover claims only

292 Mammography

520 Lithotripsy (see Lithotripsy section of this manual for details)

530 Organ Transplants

540 Post-Extended Care (PEC) Hospital (see Post Extended Care section of this manual for details)

600 QMB/EPSDT

610 QMB only

900 VFC

Additional Approval

NOTE:

New enrollment for new hospital providers has not occurred in the last several years; however, most of the provider file changes are due to a change of ownership or name change.

DXC must receive a request from the provider requesting to participate in the Medicaid Hospital Program.

The effective date of enrollment cannot be earlier than the Medicare certification date.

The hospital must be certified for participation in the Title XVIII Medicare and Title XIX Medicaid programs as a short term or children's hospital, must be licensed as an Alabama acute care hospital, have a current Certificate of Need, and be accredited by The Joint Commission.

If a hospital is enrolled as a critical access hospital with Medicare, allow providers to enroll in Alabama Medicaid as an acute care hospital. Alabama Medicaid does not recognize the distinction between acute care hospital and critical access hospital. For Alabama Medicaid, they are considered an acute care hospital.

A Medicare/Medicaid Certification and Transmittal (C&T) must be received from the Department of Public Health before the enrollment process can be completed. If we

receive a new enrollment application from a hospital before we receive the C&T, contact the Agency to determine if the C&T has been received. Do not return an application to the provider because a C&T cannot be found.

The hospital must submit a copy of their current Utilization Review Plan to be maintained with the enrollment record.

The hospital must submit a budget of cost for medical inpatient services (Medicare cost report) for its initial cost reporting period to be maintained with the enrollment record. If the hospital is a CHOW, the inpatient per diem for the old hospital should be loaded as the new hospital inpatient per diem rate and a budgeted cost report is not required.

In order to add the 292 mammography specialty, the provider/facility must submit a copy of the mammography certificate issued by FDA. The effective date of the mammography specialty will be the first of the month in which the certificate was received. The effective date of enrollment will be the Medicare certification date.

Always send a copy of the C&T and all correspondence to Provider Audit.

Add the appropriate HR rates to the Provider Outpatient Rate Panel or Provider NH/IP Rates Panel as well as a 5% outpatient reimbursement rate (DXC). Provider Audit of Medicaid will calculate all rates and notify DXC. Do not add the provider to the AMMIS until rates have been calculated.

If the hospital is government owned, the Public/Private Indicator on the Service Location Panel will need to be updated to “Public” once the hospital has been enrolled.

General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider’s screening categorical risk level is set to HIGH

Provider’s screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider’s risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Medicaid will mirror Medicare’s Change of Ownership (CHOW) policy.

Procedures Following a Change in Ownership

Institutions are to notify Medicaid of any CHOW or closure as soon as Medicare has been notified. The new owner has an option to accept assignment of the existing Medicaid Provider agreement or to reject it as outlined below:

Accept previous Owner's Medicaid Agreement results in:

- Uninterrupted participation in Medicaid
- Uninterrupted Medicaid reimbursement for claims by utilizing the previous owner's Medicaid ID number
- New owner subjected to any liabilities such as overpayments to the previous owner and any adjustment of payment
- The new owner must complete and submit a Change of Ownership form, a new Electronic Funds Transmittal Form (EFT), W-9, and Disclosure Forms. Disclosure Forms must be completed for any new owners, officers, directors, agents, managing employees, and shareholders with 5% or more controlling interest. These required forms are located on the Medicaid website.
- New owner completing the CHOW form instead of completing a new enrollment application.

Reject Previous Owner's Medicaid Agreement results in:

- Interrupted participation in Medicaid
- Contract terminated effective the date of acquisition
- The new owner's Medicaid contract will be effective the date of Medicare compliance
- The effective date for claims reimbursement not being retroactive to the date of acquisition

Acquisition followed by combination into one institution:

- If the previous owner's agreement is accepted by the new owner, the acquired institution becomes a remote location or second campus.
- If the previous owner's agreement is rejected by the new owner, the second location must undergo a full Medicare survey.

When a hospital has had a change of ownership, be sure to check to see if they participate in the PEC or Swing Bed Programs. Any changes to the hospital provider file will also need to be made to these files.

Always send a copy of the C&T and all correspondence to Provider Audit.

Name Change

A C&T must be received from the Department of Public Health before any changes can be made to the provider file. Use the Name Change and attach a copy of the W-9 form. The provider may also notify DXC in writing, e-mail or FAX. Send a copy of the C&T and all correspondence to Provider Audit.

When a hospital has a name change, be sure to check to see if they participate in the PEC or Swing Bed Programs. Any changes to the hospital provider file will also need to be made to these files.

Always send a copy of the C&T and all correspondence to Provider Audit.

Closure of Hospital

When DXC receives a copy of the Confirmation of Closure letter from the Department of Public Health, close the hospital's Medicaid enrollment using the closure date on the letter. Stamp the letter with the DXC action stamp and put the provider NPI number in the response (for the State copy).

Always send a copy of the C&T and all correspondence to Provider Audit.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

A C&T must be received from the Department of Public Health before service location address changes can be made to the provider file.

When a hospital has a change in the number of certified beds for their facility, a C&T will be received from the Department of Public Health. Update the provider file and send a copy of the C&T to Provider Audit.

The Hospital must request in writing to Provider Audit a request to change their fiscal year end date. Provider Audit will send DXC a copy of the letter to the provider granting this request.

All other changes must be submitted in writing and must be signed.

Change of Address

If a hospital has a change of address, the Department of Public Health will send DXC a C&T. The provider may notify DXC in writing by FAX or e-mail. The changes should be made due to the risk of returned mail, denied claims, etc. Contact the Deputy Director of the Division of Provider Services, at the Department of Public Health at (334) 206-5191, to make sure that the hospital has notified the Department of Public Health of the address change. Notify Provider Audit of the address change.

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

Enrollment of Subparts within a Hospital

Type

01

Specialty

010 Acute Care (For hospitals enrolling their Rehab or Psych unit)

018 Psych Subpart Enrollment

019 Rehab Subpart Enrollment

If a currently enrolled hospital has acquired an NPI for their Rehab or Psych unit, enrollment of these units will be for Crossover Only.

The effective date of enrollment will be the first day of the month in which the application is received.

Set provider status to 'X'-over.

Set the COBA indicator to Yes.

Add the “Inpatient” contract only for subparts.

Add the provider’s data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, Provider EFT Account, and Provider Medicare Number panels.

Add the appropriate HR rates that have been calculated for the enrolled acute care facility to the Provider Outpatient Rate Panel or Provider NH/IP Rates Panel as well as a 5% outpatient reimbursement rate (DXC) for the subparts.

Any changes to ownership, address, payee or name will be handled through the hospital update process.

Out-of-State Non-Bordering Providers

Specialty

010 Acute Care

- If a hospital is enrolled as a critical access hospital with Medicare, allow providers to enroll in Alabama Medicaid as an acute care hospital. Alabama Medicaid does not recognize the distinction between acute care hospital and critical access hospital. For Alabama Medicaid, they are considered an acute care hospital.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

292 Mammography

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Medicare certification verified in PECOS.
- Copy of the current state license.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

In order to add the 292 mammography specialty, the provider/facility must submit a copy of the mammography certificate issued by FDA. The effective date of the mammography specialty will be the first of the month in which the certificate was received.

Enrollment period will begin with the date of service and will end 6 months from the first date of service.

NOTE:

Out-of-state Hospitals may submit the one page Out-of-State ASC/Hospital Update Form in order to extend the enrollment period. This form is only acceptable if the OOS Hospital file did not expire more than one year prior to the submission date of the form. If the file has been expired for more than one year, an application must be submitted.

Add the appropriate HR rates to the Provider Outpatient Rate Panel or Provider NH/IP Rates Panels as well as a 5% outpatient reimbursement rate (DXC).

Name Change

Use the Name Change form or a written, signed request and attach a new W-9 form. If the provider has had a tax number change, return the request and inform the provider to complete a new enrollment application.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Can be enrolled as out of state participating with Medicaid's approval.

4.1.15 Independent Laboratory

Type

28

Specialty

280 Independent Lab

550 Department of Public Health (see instructions for State Agencies)

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Medicare certification verified in PECOS.
- Copy of the current state license or equivalent documentation.
- Copy of the current CLIA certificate
- Continued license will be received from the Department of Public Health. Medicaid enrollment dates should coincide with the licensure dates. Licensure information must be filed in the provider's contract file and the file updated as needed.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

The effective date of enrollment of an independent laboratory will be the date of issuance of license or CLIA certification. Providers who request enrollment more than 120 days after licensure/certification are enrolled on the first day of the month enrollment is received.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. See detailed CHOW policy under Section 3.8.

Name Change

Use the Name Change form or a written, signed request and attach a W-9 form. Upon receipt of the letter from the Department of Public Health, send the provider a name change form and a W-9.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Follow the same procedures as in-state providers. Provider must attach a state license or equivalent documentation.

Site Visits

Required to have a site visit completed during initial enrollment and reenrollment.

If the application is for an out-of-state non-bordering provider requiring a visit and a Medicare visit was not verified, the associated state Medicaid Agency should be contacted to determine if a visit was conducted using provided contact information from the Alabama Medicaid Agency. Document the visit by putting the individual contacted and site visit date in the notes in Feith. If this cannot be verified, the lab can be enrolled by verifying the lab is currently enrolled and active with Medicare (verify in PECOS), and is currently Clinical Laboratory Improvement (CLIA) certified or has accreditation through the College of American Pathologists (CAP) to satisfy site visit requirements.

4.1.16 Independent Nurse Practitioner (Advanced Practice Nurse)

Type

09

Specialty

090 Pediatric Nurse Practitioner

091 Women's Health Care Nurse Practitioner – Effective March 2011

092 Family Nurse Practitioner

093 Nurse Practitioner (Other) – Required Specialty

730 Neonatology (Nurse)

560 EPSDT

911 SBIRT

274 Dental Prevention

NOTE:

Independent Nurse Practitioners (INPs) will have, at a minimum, two specialties, 093, and their actual specialty.

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Must have current certification as a CRNP in the appropriate area of practice from a national certifying agency. Neonatal nurse practitioners must have certification from the Nurses Association of the American College of Obstetricians and Gynecologists. These items must be verified on the Board of Nursing website and a copy attached to application file.
- DXC enrollment staff must perform on-line verification of the Certified Registered Nurse Practitioner (CRNP) or Physician Assistant (PA) license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license
- Copy of the certified registered nurse practitioner protocol signed by a collaborating physician.
- Name and provider NPI number of the supervising physician.
- Proof of the CRNP's prescriptive authority from the licensure board. If the CRNP has prescriptive authority, add the information to the provider license file. CRNPs with prescriptive authority will have RX on the licensure card.
- In order to add the 560 specialty, the provider must submit an EPSDT Agreement and a current CLIA certificate.
- In order to add the 911 specialty, Provider Enrollment will receive a memo from the State to add this specialty to the provider's file.
- In order to add the 274 specialty, the provider should submit a written request along with their certificate of completion. DXC enrollment staff will verify providers completion of the 1st Look training by checking the list provided by ALAAP. Note: This specialty should not be a primary specialty.

- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

NOTE:

If a provider has more than one location, each location must be enrolled separately.

The effective date of enrollment will be the first day of the month in which the request for enrollment was received or the Medicare enrollment effective date. Enrollment stop date will be the expiration date of the professional license with a 45-day grace period.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, and Provider Type and Specialty panels.

Provider enrollment procedures no longer require that individual providers enroll with Medicare prior to applying to Medicaid. This is due to the often-lengthy enrollment process with Medicare. Providers will be given the option on the enrollment application to enroll with Medicaid prior to being approved to participate with Medicare.

OPTION 1

If the provider chooses to enroll with Medicaid before Medicare, we enroll the provider using the enrollment process currently used for a Pediatrician. This includes ensuring the application is complete and verifying the license information with the appropriate license board. The effective date of enrollment will be the first day of the month in which the application is received.

OPTION 2

If the provider has already been approved to participate in the Medicare program, the effective date of enrollment will be the Medicare effective date. Medicare certification can be verified in PECOS. We can then use this documentation in lieu of contacting Medicare to verify the provider's Medicare information. Obtaining this information will improve enrollment and produce more accurate tax information for 1099 reporting.

NOTE:

Nurse practitioner applications submitted for enrollment under the Tax ID of a facility such as a hospital and/or with a letter indicating the nurse practitioner is employed at this facility under special circumstances, MUST be forwarded to the Enrollment & Sanctions Unit of the Program Integrity Division for review.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed

- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Providers

Effective date will be the date of service.

4.1.17 Independent Radiology (X-Ray Clinic)

Type

29

Specialty

291 Mobile X-Ray Clinic

292 Mammography

327 Nuclear Medicine

290 Radiology

570 Physiological Lab (Independent Diagnosis Testing Facility)

Additional Approval

Provider must furnish the following:

- Medicare certification verified in PECOS (Some radiology providers may be certified by Medicare as an IDTF).
- Copy of Public Health Certificate of X-ray Inspection (Magnetic Resonance [MRI], ultrasound and other non-ionizing radiation will not have a certificate of x-ray inspection from the Alabama Department of Public Health).
- Copy of the mammography certification issued by the Food and Drug Administration (FDA) if the provider will be performing mammograms.
- In order to add the 292 mammography specialty, the provider/facility must submit a copy of the mammography certificate issued by FDA. The effective date of the mammography specialty will be the first of the month in which the certificate was received.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

The effective date of enrollment of an independent radiology facility will be the date of Medicare certification. Providers who request enrollment more than 120 days after certification are enrolled on the first day of the month in which the enrollment was received. DXC will receive a C&T from Public Health on new enrollments, change of ownership, name change and change of address “for certified x-ray facilities only.” (Public Health does not regulate mammography, MRI, ultrasound and other non-ionizing radiation used for medical imagery.)

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider’s screening categorical risk level is set to HIGH

Provider’s screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. A C&T must be received from the Department of Public Health notifying DXC that ownership has changed before the provider file can be updated. See detailed CHOW policy under Section 3.8.

Name Change

Use the Name Change form or written, signed request and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

Site Visits

Required to have a site visit completed during initial enrollment and reenrollment. A visit is not required if Medicare completed a site visit within the last 12 months.

4.1.18 Independent Rural Health Clinic

Type

58

Specialty

021 Cardiac Electrophysiology

023 Sports Medicine

081 Free Standing Rural Health Clinic

093 Certified Registered Nurse Practitioner – Effective May 11, 2011, this specialty was allowed to enroll because of the meaningful use program. However, the nurse practitioner will continue to bill under the clinic NPI number. Refer to enrollment instructions below.

095 Nurse Midwife

560 EPSDT

911 SBIRT – Effective 1/1/2010

311 Anesthesiology

931 Telemedicine Services

274 Dental Prevention

Additional Approval

To enroll as a Medicaid provider, an Independent Rural Health Clinic (IRHC) must be Medicare certified and must enroll every health care professional working in the clinic. The IRHC must have a Certified Registered Nurse Practitioner (CRNP) or a Physician Assistant (PA) employed before they can enroll the clinic. The only exception is if the facility can obtain a Certificate of Waiver from HHS, which is valid for one year only. The C&T should indicate the provider specialty. The following information is required to enroll clinics:

- C&T from Division of Licensure & Certification (DLC)—address on C&T must match address on the enrollment application. If it does not, return only the application to the provider for correction. Keep the C&T in the DXC file for the provider.
- Medicare certification verified in PECOS.
- Copy of the CLIA certificate or waiver.
- Copy of IV Sedation Certification if provider intends to perform IV Sedation procedures.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- DXC enrollment staff must perform on-line verification of the Certified Registered Nurse Practitioner (CRNP) or Physician Assistant (PA) license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license. The CRNPs and PAs with prescriptive authority will have an RX on their license. Enrollment staff must print a copy of the license verified on-line and place in the provider's file as well as on COLD.

- Budgeted Cost Report. Send cost report to Provider Audit who determines the reimbursement rate. Enrollment is not complete until this rate has been received and added to the Customary Charge Panel. Forward notification of any newly established IRHC payees to Clinic Services, Medical Services Division, Medicaid, and to the current provider representative for the IRHC Program.
- In order to add the 911 specialty, Provider Enrollment will receive a memo from the state to add this specialty to the provider's file.
- All physicians with an Alabama license, enrolled as a provider with the Alabama Medicaid Agency, regardless of location, are eligible to participate in the Telemedicine Program to provide medically necessary telemedicine services to Alabama Medicaid eligible recipients. In order to add the 931 Telemedicine Services specialty, the provider must submit the Telemedicine Services Agreement/Certification form. As stated on the Agreement/Certification form, Enrollment staff must ensure that a **sample copy** of the Provider's Informed Consent form is attached to this agreement. A sample copy has been provided for Enrollment staff. Enrollment staff must review the submitted Provider's Informed Consent form to ensure that it contains the information that is in the Agency's sample copy.
- In order to add the 274 specialty, the provider should submit a written request along with their certificate of completion. DXC enrollment staff will verify providers completion of the 1st Look training by checking the list provided by ALAAP. Note: This specialty should not be a primary specialty.

The effective date of enrollment of an independent rural health clinic will be the date of Medicare certification. Providers who request enrollment more than 120 days after certification are enrolled on the first day of the month the enrollment is approved.

Notify DXC's Adjustment Unit to add the provider to the Customary Charge Panel. Use the forms and follow the rules at the end of the section.

The following information is required to enroll clinic physicians:

Physicians must complete an enrollment application. All signatures must be original signatures.

The address on the application must match the address and phone number on the C&T. If all information is correct, a new enrollment is processed.

Perform on-line license verification to confirm the physician's license has not expired and that there are no current limitations on the physician's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD.

Start dates for the Medical Doctors (MDs) can be:

1. The first of the month in which the enrollment application was received.
2. The Medicare start date verified in PECOS.
3. Written, signed notification from the provider that "the provider started with this clinic on XX/XX/XX date."

Using the data entered on the enrollment application, determine the services the provider can bill and notify DXC's Medical Policy Unit to add the provider to the Customary Charge Panel. If the provider should retro their effective date (Medicare start date verified in PECOS), remember to notify DXC's Medical Policy Unit to retro the effective dates on the Customary Charge Panel.

Effective May 11, 2011, Nurse Practitioners were approved by the state to enroll as a provider in the clinic for enrollment purposes only due to the Meaningful Use Program. However, they will continue to bill using the clinic NPI number.

The following information is required to enroll clinic nurse practitioners:

Nurse Practitioners must complete an enrollment application. All signatures must be original signatures.

The address on the application must match the address and phone number on the C&T. If all information is correct, a new enrollment is processed.

Perform on-line license verification to confirm the nurse practitioner's license has not expired and that there are no current limitations on the nurse practitioner's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD.

Start dates for the Nurse Practitioners (NPs) can be:

4. The first of the month in which the enrollment application was received.

5. The Medicare start date verified in PECOS.

6. Written, signed notification from the provider that "the provider started with this clinic on XX/XX/XX date."

Pricing information should not be placed on the Customary Charge Panel for the nurse practitioner.

NOTE:

Physician Assistants are not enrolled. They bill using the clinic NPI number.

Addition of Services

Written request is received to provide additional services. The codes for new services will be added to the customary charge panel.

The same process applies to deleting a service.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

The IRHC must submit written notification to DLC within 30 days of the date of the ownership change. Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. The CHOW cannot be executed until DXC receives the C&T from the Department of Public Health. See detailed CHOW policy under Section 3.8.

The new owner may choose to accept the established reimbursement rate or submit a budgeted cost report to the Medicaid Agency and must submit his choice in writing to Medicaid's Q & A reimbursement program within the 30 day timeframe.

Name Change

IRHC must submit written notification to DLC and Medicaid of the name change within 30 days of the date of the name change. Once notification is received, and the name change amendment form is sent to the provider. The name change form cannot be executed until the C&T is received from DLC.

Address Change

A C&T has to be received from the Department of Public Health to change the physical address. DXC can change a payee address without notification from DPH.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Bordering Providers

Independent Rural Health Centers that are no more than 30 miles from the Alabama border are eligible to participate in the Alabama Medicaid Program as long as the bordering IRHC meets all the requirements of an in-state IRHC. However, the provider may not have a C&T.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

Customary Charge Sheets

To determine which codes, prices, and dates to forward to the Adjustment Unit to add to the customary charge panel, use the following guidelines:

Clinic Visits

New clinics and newly added MDs will **always** have clinic visit codes. Use the customary charge sheet titled **Clinic Visit Codes**. Enter the appropriate provider name, NPI number, Payee NPI, rate, and effective and end dates. Circle that this is an ADD (new provider).

Family Planning

If the enrollee, whether clinic or MD, has checked 'yes' for Family Planning, use the customary charge sheet titled **Family Planning Codes.** Enter the appropriate NPI number, payee NPI number, rate, and effective and end dates. Circle either ADD (New provider) or UPDATE (existing provider to which we are adding codes).

Prenatal

If the enrollee, whether clinic or MD, has checked 'yes' for Prenatal, use the customary charge sheet titled **Prenatal Codes.** Enter the appropriate provider name, NPI number, payee NPI number, rate, and the effective and end dates. Circle either ADD (New provider) or UPDATE (existing provider to which we are adding codes).

EPSDT

If the enrollee, whether clinic or MD, has completed the EPSDT Agreement use the customary charge sheet titled **EPSDT Codes.** Enter the appropriate provider name, provider NPI number, payee NPI number, rate, and effective and end dates. Circle either ADD (New provider) or UPDATE (existing provider to which we are adding codes).

NOTE:

The EPSDT Agreement can be found on the Medicaid Agency website. In order for the clinic or MD to enroll in the EPSDT program, the enrollee must meet the EPSDT program guidelines. Refer to the EPSDT section of this manual for details.

Vaccines for Children

IRHC providers can participate in the Vaccines for Children Program. The provider enrolls with the Public Health Department. Public Health sends Enrollment staff a listing of the clinics and physicians enrolled. Staff will update the provider file with specialty code 900 and VFC contract. Staff will forward the customary charge sheet titled **Vaccine Codes** to Medical Policy. Enter the appropriate provider name, provider NPI number, payee NPI number, and the effective and end dates. Circle either ADD (New provider) or UPDATE (existing provider to which we are adding codes.)

If the clinic or MD has been previously enrolled in the VFC program, but is receiving denials on particular codes, a VFC customary charge sheet may need to be forwarded to Medical Policy.

Preventive Health

IHRC providers also provide Preventive Health services. This requires no changes to the provider table. Medicaid sends these customary charge updates directly to Medical Policy.

4.1.19 Licensed Social Worker – QMB Only

Type

11

Specialty

116 Licensed Social Worker

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Medicare certification verified in PECOS.
- Proof of educational degree.
- Perform on-line license verification to confirm the social worker's license has not expired and that there are no current limitations on social worker's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

The effective date of enrollment will be the Medicare enrollment effective date due to the Medicare certification being a requirement. In no event will the Medicaid effective date be prior to the issue date of the professional license. Enrollment stop date will be the expiration date of the professional license with a 45-day grace period.

NOTE:

Set provider status to 'X'-over.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, Provider EFT Account and Provider Medicare Number panels.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and signed.

Out-of-State Providers

Effective date will be first day of the month in which the request for enrollment was received by DXC.

NOTE:
Set provider status to 'X'-over.

4.1.20 Lithotripsy (ESWL)

Type

01 Hospital

02 ASC

Specialty

520 Lithotripsy

Additional Approval

The following documentation is required for enrollment:

- Documentation that the Lithotripsy machine is FDA-approved.
- Copy of the lease agreement if the machine is leased.

NOTE:

If the provider is an existing ASC or hospital and wishes to participate as a lithotripsy provider, an application must be submitted for that purpose. Along with the application the documentation listed above must be submitted.

Effective date of enrollment for existing ASCs or hospitals is the first day of the month that the application is received. If an application for lithotripsy is submitted at the same time as an initial hospital enrollment, effective date of enrollment is the same as the hospital enrollment effective date. If the provider is bordering, the effective date will be the date of service provided by the applicant (cannot retro more than one year from the date of service) or the first of the month that the application is received.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Out-of-State Non-Bordering Providers

Enrollment is not applicable.

4.1.21 Nurse Midwife (Advanced Practice Nurse)

Type

09

Specialty

095 Nurse Midwife

911 SBIRT – Effective 1/1/2010

Additional Approval

The following information is required for enrollment:

- Perform on-line license verification to confirm the nurse midwife's license has not expired and that there are no current limitations on the nurse midwife's license. Print a copy of the license verified on-line and place in the provider's file on COLD
- Copy of the American College of Nurse Midwife certificate.
- Copy of the current enrollment in the American College of Nurse Midwife Continuing Competency Assessment Program.
- Copy of the certified nurse midwife protocol signed by a collaborating physician.
- A letter from the hospital granting admitting privileges for deliveries.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights
- letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.
- In order to add the 911specialty, Provider Enrollment will receive a memo from the state to add this specialty to the provider's file.

The effective date is the first date of the month in which the request for enrollment is received by DXC.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

4.1.22 Nursing Home

Type

03 SNF

03 ICF/MR

Specialty

035 Skilled Nursing Facility

030 Intermediate Care Facility

036 Nursing Home Vent (Only added if Agency Directs)

Additional Approval

The Alabama Department of Public Health (ADPH), Division of Health Care Facilities and the Division of Provider Services perform certifications and transmittals (C&T) on every nursing home and intermediate care facility. These certifications will certify or recertify and will denote any changes in a nursing home name, bed status, address change, complaint, or change in ownership.

It is important to check the following information that is listed on the C&T:

#2- Provider NPI Number.

The provider ID is not always correct on the C&T. Refer to the Nursing Home Directory.

#3-Name and Address of Facility.

This information is not always correct on the C&T. Refer to the Nursing Home Directory.

#4-Type of Action (must be completed).

#5-Date of Change of Ownership.

This date is indicated on a Change of Ownership C&T. Most of the time, the effective date is given in field #16, Remarks.

#6-Date of Survey.

This date is found on Recertification's, On Site Visits, and Complaints.

#7-Type Code.

#12-Total Facility BHP.

#13-Total Certified BHP.

#14-Bed Breakdown.

#16-Remarks.

NOTE:

C&Ts which reflect a Fiscal Year End change should be filed. Enrollment & Sanctions Unit will forward a copy of the C&T to Provider Audit. Provider Audit will take action.

The ADPH Division of Provider Services will notify DXC with a C&T when a facility is being certified in the Medicaid program. The C&T will be forwarded to DXC by the Enrollment & Sanctions Unit. A new enrollment application must be completed. Before Provider Enrollment can process the application, the unit must have the following:

A letter from CMS indicating the effective date of certification for the facility. DXC will receive this letter only if the facility is not Medicare certified at the time they enroll with Medicaid, or the facility was a private pay facility prior to Medicaid enrollment.

The effective date of the Medicaid enrollment is the Medicare effective date indicated on the C & T from Public Health unless Medicaid gives DXC another date for enrollment.

- The nursing facility must request in writing their desire to enter into the Medicaid program.
- Must have a Certificate of Need (CON) or Project Exemption. If a facility was enrolled before the CON process began it is not necessary to have a CON. Please contact the State Health Planning & Development Agency (SHPDA) at (334)242-4103 for this information. SHPDA can verify if there is CON for the facility.

General Data section of Civil Rights Compliance Information Request Package, DHHS-Office of Civil Rights letter of compliance, and most recently published newspaper article referencing the provider's nondiscrimination policy.

Send notification of the addition to: (applicable addresses are at the end of this section)

- Director of Long Term Care
- Provider Audit
- Alabama Nursing Home Association
- Fiscal Agent Liaison Division - Fiscal Agent Policy & Systems Management
- Medical & Quality Review Unit
- ADPH, Division of Provider Services / Attention: Deputy Director
- ADPH, Division of Health Care Facilities
- OBRA Screening
- Medicaid Eligibility District Office (applicable location)
- Medicaid Beneficiary Services Director, East and West Region
- Medicaid Beneficiary Services Supervisor, East and West Region
- LTC Provider / Recipient Services Unit

Mail the approval letter to the provider.

Enrollment & Sanctions Unit will notify Provider Audit Division when the C&Ts are received because the facility has to pay taxes once they are licensed.

Increase in Beds

The ADPH Division of Provider Services will notify DXC with a C&T when there has been an increase in beds for a certain facility. The C&T will be forwarded to DXC by the Enrollment & Sanctions Unit. DXC will complete the following steps:

1. Update the provider file showing increase in number of beds.
2. After DXC receives the necessary documents (C&T and the CON), a letter is sent to the nursing facility acknowledging the bed increase.
3. Distribute as follows:
    - Original to the nursing facility or intermediate care facility.
    - One copy of the letter to ADPH, Division of Health Care Facilities.
    - One copy of the letter to ADPH, Division of Provider Services / Attention Deputy Director.
    - One copy of the letter to the Medicaid Eligibility District office (applicable location)
    - One copy of the letter to Provider Audit.
    - One copy of the letter to Medicaid Beneficiary Services Director, East and West Region
    - One copy of the letter to Medicaid Beneficiary Services Supervisor, East and West Region
    - LTC Provider / Recipient Services.
4. File the letter and C&T in the contract file. The Enrollment & Sanctions Unit will forward Provider Audit a copy of the increase C&T.

Decrease in Beds

The ADPH Division of Provider Services will notify DXC with a C&T when there has been a decrease in beds for a certain facility. The C&T will be forwarded to DXC by the Enrollment & Sanctions Unit. When DXC receives this notification, complete the following steps:

1. Update the provider file showing decrease in number of beds.
2. Write a letter to the nursing facility acknowledging the bed decrease. Distribute as follows:
    - Original to the nursing facility or intermediate care facility.
    - One copy of the letter to the ADPH Division of Health Care Facilities.
    - One copy of the letter to ADPH, Division of Provider Services / Attention: Director
    - One copy of the letter to the Medicaid Eligibility District office (applicable location)
    - One copy of the letter to Provider Audit Director
    - One copy of letter to Beneficiary Services Director, East and West Region
    - One copy of letter to Beneficiary Services Region Supervisor, East and West Region
    - LTC Provider / Recipient Services Unit
    - Medical & Quality Review Unit
3. File the letter and C&T in the contract file. The Enrollment & Sanctions Unit will forward Provider Audit a copy of the bed decrease C&T.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy as outlined below. A C&T must be received from the ADPH, Division of Provider Services before ownership changes can be made to the provider file. The Enrollment & Sanctions Unit will forward a copy of the CHOW C&T to Provider Audit. The Enrollment & Sanctions Unit will notify the following of the CHOW:

Medical & Quality Review

Fiscal Agent Liaison Division - Fiscal Agent Policy & Systems Management

Provider Audit

LTC Provider / Recipient Services Unit

ADPH, Division of Provider Services / Attention: Deputy Director

ADPH, Division of Health Care Facilities

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Procedures Following a Change in Ownership

Institutions are to notify Medicaid of any CHOW or closure as soon as Medicare has been notified. The new owner has an option to accept assignment of the existing Medicaid Provider agreement or to reject it as outlined below:

Accept previous Owner's Medicaid Agreement results in:

- Uninterrupted participation in Medicaid
- Uninterrupted Medicaid reimbursement for claims by utilizing the previous owner's NPI and Medicaid ID number
- New owner subjected to any liabilities such as overpayments to the previous owner and any adjustment of payment
- The new owner must complete and submit a Change of Ownership form, a new Electronic Funds Transmittal Form (EFT), W-9, and Disclosure Forms. Disclosure Forms must be completed for any new owners, officers, directors,

agents, managing employees, and shareholders with 5% or more controlling interest. These required forms are located on the Medicaid website.

- New owner completing the CHOW form instead of completing a new enrollment application.

Reject Previous Owner's Medicaid Agreement results in:

- Interrupted participation in Medicaid
- Contract terminated effective the date of acquisition
- The new owner's Medicaid contract will be effective the date of Medicare compliance
- The effective date for claims reimbursement not being retroactive to the date of acquisition

Acquisition followed by combination into one institution:

- If the previous owner's agreement is accepted by the new owner, the acquired institution becomes a remote location or second campus.
- If the previous owner's agreement is rejected by the new owner, the second location must undergo a full Medicare survey.

Name Change

A C&T must be received from the Department of Public Health before name changes can be made to the provider file. Use the Name Change form and attach a current W-9 form. The old file should be closed sequentially with the opening of a new file. Write a letter to the nursing home. Enclose the W-9 form and the name change form. After the W-9 and the name change form are returned, write a memo to Medicaid. Send the one copy of memo to:

- ADPH, Division of Provider Services / Attention: Deputy Director
- ADPH, Division of Health Care Facilities
- Provider Audit
- Medical & Quality Review Unit
- Fiscal Agent Policy & Systems Management
- Beneficiary Services Director, East and West Region
- Beneficiary Services Supervisor, East and West Region
- Medicaid Eligibility District Office (applicable location)
- LTC Provider / Recipient Services Unit

Payee Name Change/Bank Account number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

Address Change

A C&T must be received from the Department of Public Health to change the provider's physical address. DXC can change the payee address without notification from Public Health. DXC will also request a W-9 form and address change update for address changes.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Memo Distribution:

Letters that reflect different actions are copied to certain Medicaid staff and other individuals who work outside the Medicaid Agency. DXC will forward the letters to the Agency and other State Agencies.

DXC forwards the letter to the Medicaid Eligibility District Office that handles the county where the facility is located.
DXC staff was provided a copy of the Medicaid Eligibility District Offices and will receive updates.

Letters that are cc: ADPH, Division of Health Care Facilities are sent to the secretary unless a specific person is listed.

NOTE:

The address for the ADPH, Division of Provider Services is the same as the ADPH, Division of Health Care Facilities. Memos that are forwarded to the Medicaid Beneficiary Services East and West Region will be forwarded to the Director that handles that specific county. The same applies to the Medicaid Beneficiary Services East and West Region Supervisor.

Alabama Nursing Home Association	
ADPH Division of Health Care Facilities	Alabama Department of Public Health
ADPH Division of Provider Services	Alabama Department of Public Health
Beneficiary Services Director East Region	See Medicaid District Office Distribution List
Beneficiary Services Director West Region	See Medicaid District Office Distribution List
Director of Long Term Care	Medicaid
Fiscal Agent Policy & Systems Management	Medicaid
LTC Provider/ Recipient Services Unit	Medicaid
Medicaid District Office	See Medicaid District Office Distribution List
Beneficiary Services Supervisor West Region	See Medicaid District Office Distribution List
Beneficiary Services Supervisor East Region	See Medicaid District Office Distribution List
OBRA Screening	Mental Health
Provider Audit	Medicaid

Q:\BENEFICIARY SERVICES\Beneficiary DO Directory.xls

District Office (West and East Region) Directory

Mailing Address	Handmail Address
Alabama Department of Public Health Division of Health Care Facilities RSA Tower, Suite 600 201 Monroe Street Montgomery, Alabama 36104	Alabama Department of Public Health Montgomery, Alabama 36130-3017

Address for OBRA Screening / Mental Health:

Mailing Address	Handmail Address
Director Mental Health / OBRA Screening PO Box 301410 Montgomery, Alabama 36130-1410	Director Mental Health / OBRA Screening Montgomery, Alabama 36130-1410

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

4.1.23 Off-Site EPSDT

Type

31 Physician

58 Rural Health Physician

13 Public Health Agency

56 FQHCs

Specialty

560 EPSDT

Additional Approval

Refer all calls and correspondence to the EPSDT Program Manager/Medical Services Division. Medicaid will process and forward update information to DXC. After completed agreement and attachments are received, Medicaid will forward a completed maintenance form with the effective date being the first of the month in which the request was received.

If a provider intends to provide services at different sites, each site must be treated as a distinct and separate enrollment.

The provider must meet the requirements of the Off-Site EPSDT Services protocol.

Forward customary pricing sheet to the Medical Policy Unit. Notification of enrollment should be held until enrollment is complete. Enrollment is not complete until the customary pricing update is completed.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

This action is not applicable to this provider type.

Name Change

Use the name change form.

Change of Payee

This action is not applicable to this provider type.

All Other Changes

All changes must be submitted in writing and must be signed

Out-of-State Providers

Enrollment is not applicable to this provider type.

4.1.24 Optician

Type

19

Specialty

190 Optician

Additional Approval

A completed enrollment application must be submitted and approved before the enrollment process can be initiated:

NOTE:

If a provider has more than one location, each location must be enrolled separately.

- Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, Provider EFT Account and Provider Medicare Number panels.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

The effective date of enrollment will be the first day of the month in which the request for enrollment was received or the Medicare enrollment effective date. In no event will the Medicaid effective date be prior to the issue date of the professional license. Enrollment stop date will be the expiration date of the professional license with a 45-day grace period.

Provider enrollment procedures no longer require that individual providers enroll with Medicare prior to applying to Medicaid. This is due to the often-lengthy enrollment process with Medicare. Providers will be given the option on the enrollment application to enroll with Medicaid prior to being approved to participate with Medicare.

OPTION 1

If the provider chooses to enroll with Medicaid before Medicare, we enroll the provider using the enrollment process currently used for a Pediatrician. This includes ensuring the application is complete and verifying the license information with the appropriate license board. The effective date of enrollment will be the first day of the month in which the application is received.

OPTION 2

If the provider has already been approved to participate in the Medicare program, the effective date of enrollment will be the Medicare effective date. Medicare certification can be verified in PECOS. We can then use this documentation in lieu of contacting Medicare to verify the provider's Medicare information. Obtaining this information will improve enrollment and produce more accurate tax information for 1099 reporting.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Providers

Effective date will be the date of service.

4.1.25 Optometrist

Type

18

Specialty

180 Optometrist

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Perform on-line license verification to confirm the optometrist's license has not expired and that there are no current limitations on the optometrist's license. Print a copy of the license verified on-line and place in the provider's file on COLD.
- All optometrists with an Alabama license, (like physicians), enrolled as a provider with the Alabama Medicaid Agency, regardless of location, are eligible to participate in the Telemedicine Program to provide medically necessary telemedicine services to Alabama Medicaid eligible recipients. In order to add the 931 Telemedicine Services specialty, the provider must submit the Telemedicine Services Agreement/Certification form. As stated on the Agreement/Certification form, Enrollment staff must ensure that a **sample copy** of the Provider's Informed Consent form is attached to this agreement. A sample copy has been provided for Enrollment staff. Enrollment staff must review the submitted Provider's Informed Consent form to ensure that it contains the information that is in the Agency's sample copy.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

NOTE:

If the optometrist has a 9-character license number, add the license information to the Provider License Panel.

If a provider has more than one location, each location must be enrolled separately.

The effective date of enrollment will be the first day of the month in which the request for enrollment was received or the Medicare enrollment effective date. In no event will the Medicaid effective date be prior to the issue date of the professional license. Enrollment stop date will be the expiration date of the professional license with a 45-day grace period.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, Provider EFT Account and Provider Medicare Number panels.

Provider enrollment procedures no longer require that individual providers enroll with Medicare prior to applying to Medicaid. This is due to the often-lengthy enrollment process with Medicare. Providers will be given the option on the enrollment

application to enroll with Medicaid prior to being approved to participate with Medicare.

OPTION 1

If the provider chooses to enroll with Medicaid before Medicare, we enroll the provider using the enrollment process currently used for a Pediatrician. This includes ensuring the application is complete and verifying the license information with the appropriate license board. The effective date of enrollment will be the first day of the month in which the application is received.

OPTION 2

If the provider has already been approved to participate in the Medicare program, the effective date of enrollment will be the Medicare effective date. Medicare certification can be verified in PECOS. We can then use this documentation in lieu of contacting Medicare to verify the provider's Medicare information. Obtaining this information will improve enrollment and produce more accurate tax information for 1099 reporting.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Address Change

Also update the address on the Provider Information Panel.

Out-of-State Non-Bordering Providers

Effective date will be the date of service.

4.1.26 Oral Surgeon

Type

62

Specialty

272 Oral Surgery

311 Anesthesiology (Must submit copy of their IV Sedation Certification).

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Perform on-line license verification to confirm the physician's license has not expired and that there are no current limitations on the physician's license. Print a copy of the license verified on-line and place in the provider's file on COLD.
- Copy of oral surgery certification.
- Copy of DEA certificate.
- Copy of IV Sedation Certification if provider intends to perform IV Sedation procedures.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

NOTE:

If a provider has more than one location, each location must be enrolled separately.

The effective date of enrollment will be the first day of the month, in which request for enrollment was received by DXC or the Medicaid Agency's Dental Program or the Medicare effective date. In no event will the Medicaid effective date be prior to the issue date of the professional license. Enrollment stop date will be the expiration date of the professional license with a 45-day grace period.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, Provider EFT Account and Provider Medicare Number panels.

Provider enrollment procedures no longer require that individual providers enroll with Medicare prior to applying to Medicaid. This is due to the often-lengthy enrollment process with Medicare. Providers will be given the option on the enrollment application to enroll with Medicaid prior to being approved to participate with Medicare.

OPTION 1

If the provider chooses to enroll with Medicaid before Medicare, we enroll the provider using the enrollment process currently used for a Pediatrician. This includes ensuring the application is complete and verifying the license information with the

appropriate license board. The effective date of enrollment will be the first day of the month in which the application is received.

OPTION 2

If the provider has already been approved to participate in the Medicare program, the effective date of enrollment will be the Medicare effective date. Medicare certification can be verified in PECOS. We can then use this documentation in lieu of contacting Medicare to verify the provider's Medicare information. Obtaining this information will improve enrollment and produce more accurate tax information for 1099 reporting.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Address Change

Also update the address on Provider Information Panel.

Out-of-State Non-Bordering Providers

Effective date will be the date of service.

4.1.27 Pharmacy

Type

24

Specialty

240 Retail

241 Governmental

242 Institutional

Additional Approval

After the enrollment application is received, verify the following:

- State Board of Pharmacy Number and Pharmacist's Registered Number (Alabama Pharmacy State Board (205 981-2280, Tennessee (615)-741-2718, Florida (850) 245-4292, Georgia (478) 207-1640, Mississippi (601) 354-6750.
- Verify the Pharmacy Permit number.
- Verify the Pharmacist Register number.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.
- The effective date is the first day of the month in which the request for enrollment was received by DXC.
- After enrolling a new pharmacy, the NPI should be set as the default in the IDs panel of the provider's enrollment. The "Default NPI Service Location" should be set to "Yes."

NOTE:

All out-of-state non-bordering applications should be sent to the agency for review before enrolling.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. See detailed CHOW policy under Section 3.8.

NOTE:

Notify Program Integrity of any decertified pharmacies (closed) and any pharmacy that has been decertified.

Name Change

Use the Name Change form or a written, signed request and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Providers located no more than thirty miles from the Alabama state line may be enrolled following the in-state provider process. Others can be enrolled only for the date of service or for specialty drugs not available in Alabama. Forward all requests for enrollment from out of state bordering and non-bordering pharmacies to Provider Enrollment with the Program Integrity Division of Medicaid if the request is for more than the normal one-day enrollment.

Enrollment for Part B Claims

Type

25 DME/Medical Supply Dealer

Specialty

252 DME/Medical Supply Dealer

Additional Approval

After the Pharmacy Medicare Part B/Medicaid Crossover Enrollment Application is received, verify the following:

State Board of Pharmacy Number and Pharmacist's Registered Number (Alabama Pharmacy State Board (205) 981-2280, Tennessee (615) 741-2718, Florida (850) 245-4292, Georgia (478) 207-1640, Mississippi (601) 354-6750.

- Verify the Pharmacy Permit number
- Verify the Pharmacist Register number
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Assign the following contracts:

- Durable Medical Equipment
- QMB/EPSDT Only

The effective date is the first of the month in which the written request for enrollment was received by DXC. The enrollment end date will be open ended.

Set provider status to 'X' –over.

4.1.28 Physician

Type

31

Specialty

021	Cardiac Electrophysiology		
023	Sports Medicine	272	Oral Surgeon
175	ABA Therapist (Psychiatrist Only – See note below)		
299	Mobile Provider	331	Orthopedic Surgeon
310	Allergist Rhinologist	332	Otologist, Laryngologist,
311	Anesthesiologist	312	Cardiologist
333	Pathologist	313	Cardiovascular Surgeon
336	Physical Medicine and Rehabilitation Practitioner		
314	Dermatologist	315	Emergency Medicine
337	Plastic Surgeon	316	Family Practitioner
338	Proctologist	317	Gastroenterologist
339	Psychiatrist	318	General Practitioner
340	Pulmonary Disease Specialist	341	Radiologist
319	General Surgeon	342	Thoracic Surgeon
320	Geriatric Practitioner	343	Urologist
321	Hand Surgeon	345	General Pediatrician
323	Neonatologist	750	Colon and Rectal Surgery
324	Nephrologist	770	Endocrinology
325	Neurological Surgeon	780	Hematology
328	Obstetrician/Gynecologist	790	Infectious Disease
329	Oncologist	800	Internal Medicine
330	Opthalmologist	830	Rheumatology
810	Orthopedic	911	SBIRT – Effective 1/1/2010
921	Teaching Facility	931	Telemedicine Service
922	Perinatologist		
274	Dental Prevention		

NOTE:

Specialty 175 – ABA Therapist is only allowed for a physician's enrollment if specialty 339 – Psychiatrist is included.

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Perform on-line license verification to confirm the physician's license has not expired and that there are no current limitations on the physician's license. Print a copy of the license verified on-line and place in the provider's file on COLD.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.
- In order to add the 292 mammography specialty, the provider/facility must submit a copy of the mammography certificate issued by FDA. The effective date of the mammography specialty will be the first of the month in which the certificate was received.
- In order to add the 911 specialty, Provider Enrollment will receive a memo from the state to add this specialty to the provider's file.
- Approval to add specialty 921 is given by the Alabama Medicaid Agency. Applications from new providers or emails or letters from existing providers requesting to add the 921 specialty should be forwarded to the Program Integrity Division, Enrollment and Sanctions Unit, via Workflows for coordination of approval with the Physician Program. The Enrollment & Sanctions Unit will forward the application to the Physician Program for review and approval. The Physician Program will review and send official approval to add the 921 specialty via memo to DXC through the Enrollment & Sanctions Unit. Once enrollment has been completed, DXC will notify the Physician Program.
- Approval to add specialty 922 is given by the Alabama Medicaid Agency. Providers will submit a written request for approval to the Managed Care Division, Maternity Care Program, to add this specialty. The Managed Care Division will review and send official approval to add the 922 specialty via memo to HPE through the Enrollment & Sanctions Unit. DXC will notify the Maternity Care Program and the Physician Program when the 922 specialty has been added to the provider's file. Once the addition of the specialty has been completed, an official notification with an effective date and guidance will be provided to the provider by the Maternity Care Program in collaboration with the Physician Program.
- In order to add the 820 Referring PMP specialty, the provider must submit a Patient 1st Application, on which the provider indicates that EPSDT screenings for assigned recipients will be performed by a designee.

NOTE:

For additional Patient 1st enrollment instructions, please refer to the Patient 1st section of this manual.

- In order to add the 560 EPSDT specialty, the provider must submit an EPSDT Agreement and also a current CLIA certificate if they have an internal lab at

which samples are being tested. If the provider is only collecting samples to send to an external lab, a current CLIA certificate is not required.

- All physicians with an Alabama license, enrolled as a provider with the Alabama Medicaid Agency, regardless of location, are eligible to participate in the Telemedicine Program to provide medically necessary telemedicine services to Alabama Medicaid eligible recipients. In order to add the 931 Telemedicine Services specialty, the provider must submit the Telemedicine Services Agreement/Certification form. As stated on the Agreement/Certification form, Enrollment staff must ensure that a **sample copy** of the Provider's Informed Consent form is attached to this agreement. A sample copy has been provided for Enrollment staff. Enrollment staff must review the submitted Provider's Informed Consent form to ensure that it contains the information that is in the Agency's sample copy.
- In order to add the 274 specialty, the provider should submit a written request along with their certificate of completion. DXC enrollment staff will verify providers completion of the 1st Look training by checking the list provided by ALAAP. Note: This specialty should not be a primary specialty.

NOTE:

For additional EPSDT enrollment instructions please refer to the EPSDT section of this manual.

NOTE:

If a provider has more than one location, each location must be enrolled separately.

The effective date of enrollment will be the first day of the month in which the request for enrollment was received or the Medicare enrollment effective date. In no event will the Medicaid effective date be prior to the issue date of the professional license. Enrollment stop date will be the expiration date of the professional license with a 45-day grace period.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, Provider EFT Account and Provider Medicare Number panels.

Provider enrollment procedures no longer require that individual providers enroll with Medicare prior to applying to Medicaid. This is due to the often-lengthy enrollment process with Medicare. Providers will be given the option on the enrollment application to enroll with Medicaid prior to being approved to participate with Medicare.

OPTION 1

If the provider chooses to enroll with Medicaid before Medicare, we enroll the provider using the enrollment process currently used for a Pediatrician. This includes ensuring the application is complete and verifying the license information with the appropriate license board. The effective date of enrollment will be the first day of the month in which the application is received.

OPTION 2

If the provider has already been approved to participate in the Medicare program, the effective date of enrollment will be the Medicare effective date. Medicare certification can be verified in PECOS. We can then use this documentation in lieu of contacting Medicare to verify the provider's Medicare information. Obtaining this information will improve enrollment and produce more accurate tax information for 1099 reporting.

NOTE:

To add new groups, reference the group enrollment section of the manual.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing.

Address Changes

Also update the Provider Information Panel.

Out-of-State Providers

Effective date will be the date of service.

4.1.29 Physician Employed Anesthesiology Assistants

Type

10

Specialty

101 Anesthesiology Assistant

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Perform on-line license verification to confirm the anesthesiology assistant's license has not expired and that there are no current limitations on the anesthesiology assistant's license. Print a copy of the license verified on-line and place in the provider's file on COLD
- Copy of the current certifications with the Alabama Board of Medical Examiners Certificate of Registration and National Commission for Certification of Anesthesiologist Assistants. (AA providers enrolling for a physical location outside of Alabama will not have a certification through the Alabama Board of Medical Examiners. Such providers are required to submit certification from the board of the state in which the provider is practicing and the National Commission for Certification in Anesthesiologist Assistants).
- Medicare certification verified in PECOS.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- Name and NPI number of the employing physician (found on the additional information page of the electronic application). The NPI number assigned to the physician must be verified as active.

NOTE:

If a provider has more than one location, each location must be enrolled separately.

The effective date of enrollment will be the Medicare enrollment effective due to the Medicare certification being a requirement. In no event will the Medicaid effective date be prior to the issue date of the professional license. Enrollment stop date will be the expiration date of the professional license with a 45-day grace period.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, Provider EFT Account and Provider Medicare Number panels.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed

- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Effective date will be the date of service.

4.1.30 Physician Employed Nurse Practitioner (Advanced Practice Nurse)

Type

09

Specialty

093 Nurse Practitioner (Other)

560 EPSDT

911 SBIRT - Effective 1/1/2010

274 Dental Prevention

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Perform on-line license verification to confirm the nurse practitioner's license has not expired and that there are no current limitations on the nurse practitioner's license. Print a copy of the license verified on-line and place in the provider's file on COLD
- Copy of the current certification as a CRNP in the appropriate area of practice from a national certifying agency. Neonatal nurse practitioners must submit a copy of the certification from the Nurses Association of the American College of Obstetricians and Gynecologists.
- Proof of the CRNP's prescriptive authority from the licensure board. If the CRNP has prescriptive authority, add the information to the License Panel.
- CRNPs with prescriptive authority will have RX on the licensure card.
- Name and NPI number of the employing physician (found on the additional information page of the electronic enrollment application). The NPI number assigned to the physician must be verified as active.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.
- In order to add the 560 (EPSDT) specialty, the provider must submit an EPSDT Agreement and a current CLIA certificate.
- In order to add the 911 specialty, Provider Enrollment will receive a memo from the state to add this specialty to the provider's file.
- In order to add the 274 specialty, the provider should submit a written request along with their certificate of completion. DXC enrollment staff will verify providers completion of the 1st Look training by checking the list provided by ALAAP. Note: This specialty should not be a primary specialty.

NOTE:

For additional EPSDT enrollment instructions please refer to the EPSDT section of this manual.

If a provider has more than one location, each location must be enrolled separately.

The employing physician must be an Alabama Medicaid provider and must be under the same tax number as the Nurse Practitioner.

The effective date of enrollment will be the first day of the month in which the written request for enrollment was received or the Medicare enrollment effective date. In no event will the Medicaid effective date be prior to the issue date of the professional Registered Nurse's license. Enrollment stop date will be the expiration date of the professional Registered Nurse's license with a 45-day grace period.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, Provider EFT Account and Provider Medicare Number panels.

Provider enrollment procedures no longer require that individual providers enroll with Medicare prior to applying to Medicaid. This is due to the often-lengthy enrollment process with Medicare. Providers will be given the option on the enrollment application to enroll with Medicaid prior to being approved to participate with Medicare.

OPTION 1

If the provider chooses to enroll with Medicaid before Medicare, we enroll the provider using the enrollment process currently used for a Pediatrician. This includes ensuring the application is complete and verifying the license information with the appropriate license board. The effective date of enrollment will be the first day of the month in which the application is received.

OPTION 2

If the provider has already been approved to participate in the Medicare program, the effective date of enrollment will be the Medicare effective date. Medicare verification can be verified in PECOS, We can then use this documentation in lieu of contacting Medicare to verify the provider's Medicare information. Obtaining this information will improve enrollment and produce more accurate tax information for 1099 reporting.

NOTE:

Nurse practitioner applications submitted for enrollment under the Tax ID of a facility such as a hospital and/or with a letter indicating the nurse practitioner is employed at this facility under special circumstances, MUST be forwarded to the Enrollment & Sanctions Unit of the Program Integrity Division for review.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Providers

Effective date will be the date of service.

4.1.31 Physician Employed Physician Assistant (Mid-Level Practitioner)

Type

10

Specialty

100 Physician Assistant

560 EPSDT

911 SBIRT – Effective 1/1/2010

274 Dental Prevention

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Perform on-line license verification to confirm the nurse practitioner's license has not expired and that there are no current limitations on the nurse practitioner's license. Print a copy of the license verified on-line and place in the provider's file on COLD
- Name and NPI number of the employing physician (found on the additional information page of the electronic enrollment application). The NPI number assigned to the physician must be verified as active.
- Copy of the PA's prescriptive authority from the licensure board. If the PA has prescriptive authority, add the information to the License Panel.
- PAs with prescriptive authority will have RX on the licensure card.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.
- In order to add the 560 (EPSDT) specialty, the provider must submit an EPSDT Agreement and a current CLIA certificate.
- In order to add the 911 specialty, Provider Enrollment will receive a memo from the state to add this specialty to the provider's file.
- In order to add the 274 specialty, the provider should submit a written request along with their certificate of completion. DXC enrollment staff will verify providers completion of the 1st Look training by checking the list provided by ALAAP. Note: This specialty should not be a primary specialty.

NOTE:

For additional EPSDT enrollment instructions please refer to the EPSDT section of this manual.

If a provider has more than one location, each location must be enrolled separately.

The effective date of enrollment will be the first day of the month in which the request for enrollment was received or the Medicare enrollment effective date. In no event will the Medicaid effective date be prior to the issue date of the professional license.

Enrollment stop date will be the expiration date of the professional license with a 45-day grace period.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, Provider EFT Account and Provider Medicare Number panels.

Provider enrollment procedures no longer require that individual providers enroll with Medicare prior to applying to Medicaid. This is due to the often-lengthy enrollment process with Medicare. Providers will be given the option on the enrollment application to enroll with Medicaid prior to being approved to participate with Medicare.

OPTION 1

If the provider chooses to enroll with Medicaid before Medicare, we enroll the provider using the enrollment process currently used for a Pediatrician. This includes ensuring the application is complete and verifying the license information with the appropriate license board. The effective date of enrollment will be the first day of the month in which the application is received.

OPTION 2

If the provider has already been approved to participate in the Medicare program, the effective date of enrollment will be the Medicare effective date. Medicare certification can be verified in PECOS. We can then use this documentation in lieu of contacting Medicare to verify the provider's Medicare information. Obtaining this information will improve enrollment and produce more accurate tax information for 1099 reporting.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number or Medicare number, they must complete a new Medicaid enrollment application and a new number is assigned.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Providers

Effective date will be the date of service.

4.1.32 Physiological Lab (X-Ray Clinic)

Type

29

Specialty

570 Physiological Lab (Independent Diagnostic Testing Facility) IDTF

Additional Approval

The facility must specify the provider's specialty as physiological lab. Physiological lab can only have one specialty.

- Provider must furnish the following:
- Medicare certification verified in PECOS.
- Copy of the current state license.
- Completed Physician's Supervisory Certification.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

The effective date of enrollment will be the first day of the month in which the request for enrollment is received by DXC or issue date of license, whichever is later.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. See detailed CHOW policy under Section 3.8.

Name Change

Use the Name Change form or a written, signed request and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Providers

Same as in-state.

4.1.33 Plan First Enrollment Procedures

The following outlines the policies and procedures regarding Plan First Enrollment.

Policies

1. Any Medicaid enrolled provider (routinely these are: FP, GP, OB/GYN, Nurse Midwife, Nurse Practitioner) may enroll in the Plan First program.
2. Only enrolled Plan First providers may provide services to a Plan First enrollee.

Procedures

1. Providers wishing to enroll must complete the Plan First Agreement:
   a. The Plan First agreement is located on the required attachment link in the electronic enrollment application for new providers.
   b. For existing providers, the provider should be directed to the Medicaid Agency website to download the agreement.
2. Compare the demographic information included on the enrollment form to the information provided on the agreement. Update fields as necessary following normal DXC operating procedures, contacting the provider as may be required to verify what information is correct.

NOTE:

The contact information is for internal use and should not be indicated on the Provider Information Panel.

3. Place a specialty code of 700 on the provider file with the effective date being the first day of the month in which the agreement was signed. An open-ended stop date should be used.
   a. If the agreement is for a group number, place a 700 code on the group provider file and all providers that may be associated with that group. There is a block on the agreement indicating whether it is a group or individual enrollment. FQHC's and RHC's should be considered group enrollments; however, these providers should send a list of individual practitioners within their clinics to also be considered as Plan First providers.
   b. If the agreement is for an individual, place a 700 code only for the provider file indicated.

4.1.34 Post Extended Care (PEC) Provider

Type

01

Specialty

540 Post Extended Care (PEC)

Additional Approval

The hospital must be enrolled with Medicaid as an in-state participating acute care facility. The provider must complete an application to provide PEC services. The provider will furnish the effective date for enrollment. The effective date is the date the facility started providing PEC services.

- Add the specialty code to the provider file and update the PEC listing.
- Notify Provider Audit so rates can be established.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

This action is not applicable to this provider type.

Name Change

This action is not applicable to this provider type.

Change of Payee

This action is not applicable to this provider type.

All Other Changes

This action is not applicable to this provider type.

Out-of-State Providers

This action is not applicable to this provider type.

NOTE:

Any changes to ownership, address, or name will be handled through the hospital update process.

4.1.35 Prenatal Education

Type

13 Public Health Agency

55 Private Prenatal Education

Specialty

183 Early Intervention Services

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Names and verification of valid licensure for each of the provider's instructors (for unlicensed instructors, providers must supply DXC with the name and resume of the physician supervising the instructor and maintain documentation sufficient to demonstrate their availability to the instructors). A resume of education and experience must be submitted for each instructor.
- A narrative verifying what type of training that will be provided by the facility to a new employee prior to the employee becoming a Prenatal Education instructor.
- A copy of the Prenatal Education curriculum that includes course content and objectives for each class.
- Evaluation process for pre/post instruction.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

After all the information is received, DXC will forward the information to the Maternity Care Program Associate Director for approval. The Maternity Care Program will review the curriculum and credentials to determine the potential provider's qualifications. If approved, the curriculum, credentials and statement describing the training to be provided to new employees will be stamped **'approved'**. The reviewer's initials and the date the information was approved will be placed under the approval stamp. The provider must be sent a copy of the approved curriculum, credentials, and statement describing the training provided to new employees for their file. This information, along with the forms listed below, will be returned to DXC so that the enrollment process can be completed.

- Biographical Data Sheet/Consent Form.
- Class Attendance Record.
- Evaluation Documentation Record.
- Patient Referral Form.

These forms can be duplicated by the provider.

If the submitted information is not approved, the staff person in the Plan Development/Contracts Unit will inform the potential provider of the reason why the

information is not acceptable and request that the information be corrected and resubmitted. DXC will also be apprised of this action.

NOTE:

All County Health Departments are currently enrolled as Prenatal Education Providers.

- The effective date of enrollment will be the first day of the month in which the request for enrollment was received by DXC.
- Send pricing information to the Medical Policy Unit of DXC to add the appropriate procedure code to the customary charge panel.

Health Departments are paid $18.20 per class.

Private Prenatal Education providers are paid $10 per class.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Providers must submit the Change of Ownership (CHOW) form, new provider agreement, new disclosures, new W-9, and new EFT form.

Name Change

Use the Name Change or a written, signed request and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Providers

Enrollment is not applicable to this provider type.

4.1.36 Preventive Health Education (Early Intervention Services)

Type

13 Public Health Agency

55 Private Prenatal Education

Specialty

183 Early Intervention Services

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Verification of a valid license for all staff members who will be teaching or directly supervising instruction of the Adolescent Pregnancy Prevention classes.
- Title and completion date of Medicaid approved training for non-medical professionals.
- Specific written curriculum for the class, including specific course content and objectives that must be prior approved.
- A statement or evidence verifying the type of training that will be provided to a new employee prior to the employee becoming an instructor. The statement or evidence must be submitted for an employee that is not a medical professional, but is a health education instructor.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.
- Evaluation process for pre/post instructions.

Upon receipt of the application, the packet should be forwarded to the Medical Services Division of Medicaid. Medicaid will collect the additional items listed above. Upon approval of the completed agreement and collected attachments, Medicaid will forward a completed maintenance form to DXC. The effective date of enrollment will be the first of the month in which the request was received.

A provider with more than one site must enroll for each separate location where the medical and educational records will be housed.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment

- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Update Correspondence and Inquiries

Forward all calls and update correspondence to the Medical Services Division. Medicaid will process and forward update information to DXC.

Out-of-State Providers

Enrollment is not permitted for out-of-state providers.

4.1.37 Private Duty Nursing

Type

52

Specialty

580 Private Duty Nursing

600 QMB/EPSDT

590 T A Waiver

Additional Approval

In addition to the enrollment application the provider must also submit the following:

- Copy of a valid and current year's Alabama business license or State license. The license must include the physical location of the business, and the business cannot be located more than thirty miles from the Alabama state line.
- A copy of the RN license must be provided to enroll.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

The effective date of enrollment is the first day of the month in which the request for enrollment is received by DXC. The enrollment end date will be open ended.

NOTE:

Private Duty Nursing providers can also enroll to provide services under the Technology Assisted Waiver for Adults (TA Waiver) Program. DXC must have approval from the Medicaid Agency to enroll a Private Duty Provider for the TA Waiver. Providers wishing to add the TA Waiver to their enrollment should submit a letter requesting addition of this specialty to DXC. Once received, DXC should send the letter to the Enrollment & Sanctions Unit for coordination and approval from the program manager for the TA Waiver program.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Providers must submit the Change of Ownership (CHOW) form, new provider agreement, new disclosures, new W-9, and new EFT form.

Name Change

Use the Name Change form or a written, signed request and attach a W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

Site Visits

Required to have a site visit completed during initial enrollment and reenrollment. A visit is not required if Medicare completed a site visit within the last 12 months.

4.1.38 Provider Based Rural Health Clinic

Type

58

Specialty

021	Cardiac Electrophysiology	112	Psychologist
023	Sports Medicine	140	Podiatrist
185	Provider Based Rural Health Clinic	600	QMB/EPSDT (Required for specialties 112 & 140
560	EPSDT	931	Telemedicine Services

911 SBIRT – Effective 1/1/2010

311 Anesthesiology

093 Certified Registered Nurse Practitioner – Effective May 11, 2011, this specialty was allowed to enroll because of the Meaningful Use Program. However, the nurse practitioner will continue to bill under the clinic NPI number. Refer to enrollment instructions below.

095 Nurse Midwife

274 Dental Prevention

Additional Approval

To enroll as a Medicaid provider, a Provider Based Rural Health Clinic (PBRHC) must be Medicare certified. The PBRHC must have a Certified Registered Nurse Practitioner (CRNP) or a Physician Assistant (PA) employed before they can enroll the clinic. The only exception is if the facility can obtain a Certificate of Waiver from HHS, which is valid for one year only.

The following information is required to enroll a PBRHC:

- A C&T from the Department of Public Health - the address on the C&T must match address on the enrollment application. Also, the C&T should indicate the provider's specialty.
- Medicare participation approval verified in PECOS (hospital based RHCs must have the same fiscal year end (FYE) date as the hospital. The hospital FYE can be verified by using the Provider Information Search Page or Provider Mini-Search Panel by entering the name or tax number of the hospital that owns the clinic.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- Copy of the CLIA certificate or waiver
- Copy of IV Sedation Certification if provider intends to perform IV Sedation procedures.
- DXC enrollment staff must perform on-line verification of the Certified Registered Nurse Practitioner (CRNP) or Physician Assistant (PA) license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license. The CRNPs and PAs with prescriptive authority will have an RX on their license. Enrollment staff must

print a copy of the license verified on-line and place in the provider's file as well as on COLD.

- Budgeted Cost Report. Send cost report to Q&A reimbursement, who determines the reimbursement rate. Enrollment is not complete until this rate has been received and added to the customary charge panel. Forward notification of any newly established PBRHC payees to Clinic Services, Medical Services Division, Medicaid, and to the current provider representative for the PBRHC Program.
- Send notification to Q&A Reimbursement for additional information required.

The effective date of enrollment is the date of Medicare certification. If a provider requests enrollment more than 120 days after Medicare certification, the effective date of enrollment is the first day of the month the application is approved.

The physician, nurse practitioner, psychologist and podiatrist must complete an enrollment application. Enrollment staff must perform on-line license verifications to confirm that the provider's license has not expired and that there are no current limitations on the provider's license. Print a copy of the license verified on-line and place in the provider's file on COLD.

The application's address must match the address and phone number on the C&T.

Start dates for the physicians, nurse practitioners, psychologists and podiatrists can be:

1. The first of the month in which the enrollment application was received.
2. The Medicare start date verified in PECOS.
3. Written, signed notification from the provider that "the provider started with this clinic on XXXXX date."

- All physicians with an Alabama license, enrolled as a provider with the Alabama Medicaid Agency, regardless of location, are eligible to participate in the Telemedicine Program to provide medically necessary telemedicine services to Alabama Medicaid eligible recipients. In order to add the 931 Telemedicine Services specialty, the provider must submit the Telemedicine Services Agreement/Certification form. As stated on the Agreement/Certification form, Enrollment staff must ensure that a **sample copy** of the Provider's Informed Consent form is attached to this agreement. A sample copy has been provided for Enrollment staff. Enrollment staff must review the submitted Provider's Informed Consent form to ensure that it contains the information that is in the Agency's sample copy.
- In order to add the 911 specialty, Provider Enrollment will receive a memo from the state to add this specialty to the provider's file.
- In order to add the 274 specialty, the provider should submit a written request along with their certificate of completion. DXC enrollment staff will verify providers completion of the 1st Look training by checking the list provided by ALAAP. Note: This specialty should not be a primary specialty.

NOTE:

Pricing information should not be placed on the Customary Charge Panel for the nurse practitioner. Physician Assistants are not enrolled. Nurse Practitioners and

Physician Assistants bill using the clinic NPI number. Appropriate documentation of current licenses and certifications are required.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

The PBRHC must submit written notification to DLC within 30 days of the date of the ownership change. Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. The CHOW cannot be executed until Medicaid receives the C&T from the Department of Public Health. See detailed CHOW policy under Section 3.8.

Medicare will reenroll if the RHC changes provider type—that is, the Provider-Based RHC becomes an independent RHC. If the provider type does not change, Medicare will not reenroll and the Medicaid enrollment will not change.

If Medicare reenrolls due to the provider type changing, terminate Medicaid enrollment. A new enrollment application must be executed (same as IRHC).

The new owner may choose to accept the established reimbursement rate or submit a budgeted cost report to the Medicaid Agency and must submit his choice in writing to Medicaid's Q&A reimbursement program within the 30 day timeframe.

Name Change

PBRHC must submit written notification to DLC and Medicaid of the name change within 30 days of the date of the name change. Changes cannot be executed until the C&T is received from DLC. Send one executed Signature Page to the provider with a cover letter.

Address Change

A C & T has to be received from the Department of Public Health to change the physical address. DXC can change the payee address without notification from DPH. Requests to change the payee address must be submitted to DXC in writing.

Change of Payee

This action is not applicable to this provider type.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

4.1.39 Psych Hospital Over 65

Type

01

Specialty

011 Inpatient Psychiatric Hospital over 65

Additional Approval

A Medicare/Medicaid Certification and Transmittal (C&T) must be received from the Department of Public Health before the enrollment process can be completed.

A provider must meet the following requirements:

- Must be licensed as an Alabama free-standing acute geriatric psychiatric hospital.
- Must be accredited by The Joint Commission.
- Have on staff at least one full-time board certified geriatric psychiatrist/geriatrician; or a full-time board certified adult psychiatrist with a minimum of 3 years' experience caring for geriatric patients 65 or older.
- Employ only staff who meets training/certification standards in the area of geriatric psychiatry as defined by the State's mental health authority.
- Recognized as a teaching hospital, and affiliated with at least one four-year institution of higher education with a multi-disciplinary approach to the care and treatment of geriatric patients with serious mental illnesses.
- Must provide outpatient and community liaison services throughout the State of Alabama directly or through contract with qualified providers.
- Must be under the jurisdiction of the State's mental health authority.
- Must submit a current utilization review plan.
- The UR Plan is forwarded to the Managed Care Quality Assurance Program for approval. If the plan does not meet Medicaid requirements, the nurse reviewing the Plan will write a letter to the hospital stating the deficiencies. A copy will be forwarded to DXC for the provider file. Once the UR Plan is approved, DXC will receive an approval letter from Quality Assurance.
- Must submit a budget of cost for inpatient services.
- The budget is forwarded to Provider Audit. Provider Audit will notify DXC of approval/rate.
- Verify Medicare certification in PECOS.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

The effective date of enrollment cannot be earlier than the Medicare certification date.

Send a copy of the C&T and all correspondence to Provider Audit.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. A C&T has to be received from the Department of Public Health notifying DXC of a hospital's change of ownership before the changes can be made to the provider file. See detailed CHOW policy under Section 3.8.

Name Change

A C&T must be received from the Department of Public Health before any changes can be made to the provider file. The provider may also notify DXC in writing, via fax or e-mail.

Provider is mailed a name change amendment with Supplemental Information Form and an Electronic Funds Transfer Authorization Agreement form. The provider should submit a new W-9 as requested on the Supplemental Info form.

Send a copy of the C&T and all correspondence to Provider Audit.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

When a hospital has a change in the number of certified beds, a C&T will be received from the Department of Public Health. DXC updates the provider file and sends a copy of the C&T to Provider Audit.

The hospital must send a written request to Provider Audit to change their fiscal year end date. Provider Audit will send DXC a copy of the letter to the provider granting this request.

If a hospital has a change of address, the Department of Public Health will send DXC a C&T. DXC will make this change due to the risk of returned mail, denied claims, etc. Contact the Deputy Director of the Division of Provider Services, Department of Public Health, at 334-206-5191 to make sure the hospital has notified him.

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

4.1.40 Psych Hospital Under 21

Type

01

Specialty

017 Inpatient Psychiatric Hospital under 21 (Peds Psychiatric)

Additional Approval

A hospital must meet the following requirements in order to acquire approval:

- Must be certified by Medicare. Verify in PECOS.
- Must be licensed as an Alabama psychiatric hospital.
- Must be accredited by The Joint Commission.
- Must have a distinct unit for children and adolescents.
- Must have a separate treatment for children and adolescents.
- A Medicare/Medicaid Certification and Transmittal (C&T) must be received from the Department of Public Health before the enrollment process can be completed.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- The hospital must submit a copy of their current Utilization Review Plan. The UR Plan is forwarded to the Managed Care Quality Assurance Program for approval. If the plan does not meet Medicaid requirements, the nurse reviewing the Plan will write a letter to the hospital stating the deficiencies. A copy will be forwarded to DXC for the provider file. Once the UR Plan is approved, DXC will receive an approval letter from Quality Assurance.
- The hospital must submit a budget of cost for medical inpatient services (Medicare cost report) for its initial cost reporting period. The budget is forwarded to Provider Audit. Provider Audit will notify DXC of approval/rate.

The effective date cannot be earlier than the date of the Medicare certification.

Send a copy of the C&T and all correspondence to Provider Audit.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. A C&T has to be received from the Department of Public Health notifying DXC of a hospital's change of ownership before changes can be made to the provider file. See detailed CHOW policy under Section 3.8.

The hospital must submit a current Utilization Review Plan. The UR Plan is forwarded to the Managed Care Quality Assurance Program. QA will notify DXC in writing of approval. The CHOW cannot be completed without an approved UR Plan.

The hospital must also submit a Medicare Terminating Cost Report to Provider Audit. The provider is instructed to do this in the cover letter.

When DXC receives the C&T, approval from QA on the UR Plan the effective date of the CHOW is the date indicated on the C&T.

Send a copy of the C&T and all correspondence to Provider Audit.

Name Change

A C&T must be received from the Department of Public Health before any changes can be made to the provider file. The provider may also notify DXC in writing, e-mail or fax.

Provider is mailed a name change amendment with Supplemental Information Form and an Electronic Funds Transfer Authorization Agreement form. The provider should submit a new W-9 as requested on the supplemental Information Form.

Send a copy of the C&T and all correspondence to Provider Audit.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing and must be signed. When a hospital has a change in the number of certified beds, a C&T will be received from the Department of Public Health. Update the provider file and send a copy of the C&T to Provider Audit.

The hospital must request in writing to Provider Audit to change their fiscal year end date. Provider Audit will send DXC a copy of the letter to the provider granting this request.

If a hospital has a change of address, the Department of Public Health will send DXC a C&T. The provider may notify DXC in writing by fax or e-mail before DPH notifies DXC. Contact the Deputy Director of the Division of Provider Services, DPH, at 206-5191 to make sure that the hospital has notified him.

When the C&T is received from DPH, DXC can make the address change due to the risk of returned mail, denied claims, etc.

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

Out-of-State Providers

Enrollment is not applicable to this provider type.

4.1.41 Rehab Hospital (Crossover Only)

Type

01

Specialty

012 Rehabilitation Hospital

600 QMB/EPSDT

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Medicare certification verified in PECOS.
- Copy of the current state license.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

If a provider has more than one location, each location must be enrolled separately.

The effective date of enrollment is the first day of the month in which the request for enrollment is received by DXC. The enrollment end date will be open ended.

Set provider status to 'X'-over.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, Provider EFT Account and Provider Medicare Number panels.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or written, signed request and attach a W-9 form.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and signed.

Out-of-State Providers

Enrollment is not applicable to this provider type.

4.1.42 Swing Bed Hospital

Type

03

Specialty

035 Swing Bed Hospital (Skilled Nursing BHP)

950 Swing Bed – Effective May 2010

Additional Approval

A hospital must meet the following requirements in order to acquire approval:

- Must be enrolled with Medicaid as an in-state participating acute care facility.
- Must have fewer than 100 beds (rural hospital).
- Must be a Medicare swing bed provider.
- Must have a Certificate of Need (CON) for swing beds.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

The provider must complete an enrollment application to provide swing-bed services. If these conditions are met add the specialty code to the provider file and update the Swing Bed Listing. Notify Provider Audit so rates can be established.

(Any changes to ownership, address, payee or name will be handled through the hospital update process.)

The effective date is the date the enrollment application is received by DXC.

Update the swing bed listing.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. The swing bed listing will need to be updated. See detailed CHOW policy under Section 3.8.

Name Change

A name change requires file maintenance update. A copy of the hospital contract Amendment should be placed in the provider's Swing bed file.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Providers

Enrollment is not applicable to this provider type.

4.1.43 Transportation

Type

26

Specialty

260 Ground Ambulance

261 Air Ambulance (Helicopter)

268 Air Ambulance (Fixed Wing)

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Medicare certification verified in PECOS.
- If the transportation facility is owned by the hospital, the hospital's Medicare certification is applicable.
- Current state license or permit from the Department of Public Health. Air Ambulance providers will not have a current state license or permit from the Alabama Department of Public Health.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

The effective date of enrollment will be the Medicare enrollment effective date due to the Medicare certification being a requirement. However, if a provider's request for enrollment is received more than 120 days after the date of their Medicare certification, then the effective date will be the first day of the month the enrollment is initially received by DXC.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, Provider EFT Account and Provider Medicare Number panels.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership/New Tax ID Number

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. See detailed CHOW policy under Section 3.8.

Name Change

Use the Name Change form or a written request from the provider and attach a W-9 form.

Payee Name Change and Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Out-of-state providers are enrolled for date of service only. The enrollment application must be submitted for each date of service to be billed.

Site Visits

Required to have a site visit completed during initial enrollment and reenrollment.

If the application is for an out-of-state non-bordering provider requiring a visit and a Medicare visit was not verified, the associated state Medicaid Agency should be contacted to determine if a visit was conducted using provided contact information from the Alabama Medicaid Agency. Document the visit by putting the individual contacted and site visit date in the notes in Feith.

4.2 STATE AGENCIES

The Alabama Medicaid Agency enrolls other State Agencies to provide a variety of nontraditional Medicaid services. Each State Agency must have a contractual agreement with Medicaid which encompasses the service(s) they will provide either directly or indirectly. Prior to entering into a contractual agreement with the State Agency, Medicaid ensures that the provider qualifications of the State Agency are met. A State Agency may also subcontract with other qualified providers who wish to provide the specific service(s) if the provider criteria are met. A state Agency who subcontracts with a provider is responsible for enrolling only those providers who meet Medicaid's enrollment criteria.

State agencies enrolled as a Medicaid provider and the requirements that must be met before the enrollment process is complete are listed in the following sections:

4.2.1 The Alabama Department of Children's Rehabilitation Services (CRS) / Sparks Clinic

(Enrolled as the administering agency/provider for children's specialty services)

Type

57

Specialty

015 Children's Specialty (Required Specialty for CRS Providers)

021 Cardiac Electrophysiology

023 Sports Medicine

093 Nurse Practitioner

273 Orthodontia (requires Agency approval)

560 EPSDT

850 Sparks Rehab Center

931 Telemedicine

990 Hemophilia

995 Radiology Clinics

274 Dental Prevention

CRS is a specialty clinic that has contractual agreement with the Medicaid Agency. They may contract with any qualified provider who meets Medicaid enrollment criteria (i.e., physicians, and orthodontists). CRS is a payee for children's specialty services.

Physicians

Physicians affiliated with children's specialty clinics are enrolled with their own NPI, which links them to the clinic. The provider type is:

Type

57

Specialty

015 Children's Specialty (Required Specialty for CRS Physician Providers)

274 Dental Prevention

See Provider Type Specialty Cross Reference Panel for valid Specialty values for CRS Physicians

- Perform on-line license verification to confirm the physician's license has not expired and that there are no current limitations on the physician's license. Print a copy of the license verified on-line and place in the provider's file on COLD.

- All physicians with an Alabama license, including CRS physicians, enrolled as a provider with the Alabama Medicaid Agency, regardless of location, are eligible to participate in the Telemedicine Program to provide medically necessary telemedicine services to Alabama Medicaid eligible recipients. In order to add the 931 Telemedicine Services specialty, the provider must

submit the Telemedicine Services Agreement/Certification form. As stated on the Agreement/Certification form, Enrollment staff must ensure that a **sample copy** of the Provider's Informed Consent form is attached to this agreement. A sample copy has been provided for Enrollment staff. Enrollment staff must review the submitted Provider's Informed Consent form to ensure that it contains the information that is in the Agency's sample copy.

- In order to add the 274 specialty, the provider should submit a written request along with their certificate of completion. DXC enrollment staff will verify providers completion of the 1st Look training by checking the list provided by ALAAP. Note: This specialty should not be a primary specialty.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Sparks Clinic

Type

57

Specialty

850 Sparks Rehab Center

274 Dental Prevention

Sparks Clinic is enrolled as a provider of children's specialty services.

Sparks Clinic is a children's specialty clinic that has a contractual agreement with the Medicaid Agency. Sparks Clinic may subcontract with any qualified provider who meets Medicaid enrollment criteria (i.e., physicians). Sparks Clinic is a payee for children's specialty services.

- Sparks Clinic should submit to DXC a memo and pertinent documentation to add providers with which they have subcontracted.
- Forward customary charge sheet to the Medical Policy Unit for group CRS enrollments only. Effective 3/31/2014, individuals within a group will no longer receive rates. Notification of enrollment should be held until enrollment is complete. Enrollment is not complete until the customary charge update is completed (for group enrollments only).
- There is very little activity with Sparks. Sparks will send you a memo letting you know when a doctor has left and when a new staff member is hired.
- In order to add the 274 specialty, the provider should submit a written request along with their certificate of completion. DXC enrollment staff will verify providers completion of the 1st Look training by checking the list provided by ALAAP. Note: This specialty should not be a primary specialty.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Certified Registered Nurse Practitioners (CNRPs)

Certified Registered Nurse Practitioners (CRNPs) affiliated with children's specialty clinics are enrolled with their own NPI, which links them to the clinic. The provider type is:

Type

57

Specialty

093 Nurse Practitioner

015 Children's Specialty (Required Specialty for CRS Physician Providers)

274 Dental Prevention

See Provider Type Specialty Cross Reference Panel for valid Specialty values for CRS CRNPs

- Copy of the current certification as a CRNP in the appropriate area of practice from a national certifying agency.
- DXC enrollment staff must perform on-line verification of the Certified Registered Nurse Practitioner (CRNP) license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license
- Name and provider NPI number of the supervising physician.
- Proof of the CRNP's prescriptive authority from the licensure board. If the CRNP has prescriptive authority, add the information to the provider license file. CRNPs with prescriptive authority will have RX on the licensure card.
- Perform on-line license verification to confirm the nurse practitioner's license has not expired and that there are no current limitations on the nurse practitioner's license. Print a copy of the license verified on-line and place in the provider's file on COLD.
- In order to add the 274 specialty, the provider should submit a written request along with their certificate of completion. DXC enrollment staff will verify providers completion of the 1st Look training by checking the list provided by ALAAP. Note: This specialty should not be a primary specialty.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

4.2.2 The Alabama Department of Children's Rehabilitation Services (CRS)

(Enrolled as the administering agency/provider for Audiology and Therapy services)

Type

17

Specialty

171 Occupational Therapist

170 Physical Therapist

600 QMB / EPSDT

173 Speech/Hearing Therapist

015 Children's Specialty (Required Specialty for CRS Providers)

Type

20

Specialty

200 Audiologist

015 Children's Specialty (Required Specialty for CRS Providers)

The therapist will submit the completed special application with all attachments to: State Supervisor for Professional Services, CRS, P.O. Box 11586, Montgomery, AL 36111-0586. The CRS Supervisor will prepare and forward to DXC a memorandum providing provider's name and effective date for enrollment along with the special application, Statement of Compliance, and all required attachments to DXC for review, approval and addition to Medicaid files. The special application and Statement of Compliance must have original signatures. Add specialty 600 for each therapist enrolled.

The following required attachments must accompany the application. The attachments are as follows:

- Speech Pathologist A copy of their current license from the Alabama Board of Examiners Speech Pathology and Audiology.
- Occupational Therapist A copy of their current license.
- Physical Therapist A copy of their current license.
- Audiologist A copy of their current license.

For all providers listed above:

- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Upon completion, DXC will notify ADRS/CRS at the above address.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

4.2.3 Alabama Department of Senior Services (ADSS)

(Enrolled as an administering agency/provider for the Elderly/Disabled waiver.)

Type

53

Specialty

670 ADSS (Elderly and Disabled)

The ADSS has a contractual agreement with the Alabama Medicaid Agency to provide Elderly/Disabled waiver services. ADSS may subcontract with any qualified provider who meets Medicaid's enrollment criteria. ADSS is the payee for E/D waiver services.

ADSS is the payee for the Elderly/Disabled Waiver Services and no other provider information is added to the DXC file for subcontracting providers.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing to Medicaid and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

4.2.4 Alabama Department of Education

(Enrolled as an administering agency/provider for Audiology, Rehabilitation, Therapy and Vision Services.)

Type

12

Specialty

930 School Based Services

NOTE:

Specialty 930 is required for all provider types that are associated with the Department of Education.

The Department of Education has a contractual agreement with the Alabama Medicaid Agency to provide audiology, rehabilitation, therapy (i.e., speech therapy, physical therapy, and occupational therapy) and vision services. The Department of Education may subcontract with any qualified provider who meets Medicaid's enrollment criteria. The State Department of Education is the payee for above referenced therapy services. All NPI numbers should pay to the State Department of Education.

- The Department of Education should submit to DXC an application for the school at which the services will be rendered.
  - If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
  - If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

The effective date of enrollment, for applications initially received on or after March 23, 2004, will be the first day of the month in which the written request for enrollment is received by DXC.

The effective date shall be no earlier than October 1, 2003. Enrollment stop date will be open ended. More than one service may be indicated on the application. Services not indicated on the initial application that are to be added at a later time will require a separate application.

DXC will verify that the physical address and superintendent indicated for the school system is the address and superintendent given in the Alabama Department of Education Directory. Verification of credentials for the providers performing the services is the responsibility of the Department of Education.

DXC will notify Medicaid within 2 days of the enrollment of new Medicaid providers.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed

- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form and attach a current W-9 form.

All Other Changes

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

4.2.5 Alabama Department of Mental Health (ADMH/ID)

Type

53

Specialty

680 ADMH/ Intellectual Disabilities Waiver (ID)

Enrolled as the administering agency/provider for the Mentally Retarded.

The ADMH/ID has a contractual agreement with the Alabama Medicaid Agency. The ADMH/ID may subcontract with any qualified provider, who meets Medicaid's enrollment criteria.

- The ADMH/ID is the payee for all ID waiver services and at the approval of ADMHID performing providers are added to the DXC file.
- ADMH/ID will forward a provider file update request to DXC.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing to Medicaid and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

4.2.6 Alabama Department of Mental Health (ADMH)

Type

53

Specialty

690 ADMH Living At Home Waiver (LHW)

Enrolled as the administering agency/provider for the Living at Home Waiver (LHW).

- The ADMH has a contractual agreement with the Alabama Medicaid Agency. The ADMH may subcontract with any qualified provider, who meets Medicaid's enrollment criteria.
- ADMH is the payee for all LHW waiver services and at the approval of ADMH performing providers are added to the DXC file.
- ADMH will forward a provider file update request to DXC.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing to Medicaid and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

4.2.7 Technology Assisted Waiver for Adults (TA Waiver)

Type

53

Specialty

590 TA Waiver

The Technology Assisted (TA) Waiver for Adults serves individuals who received private duty nursing services through the EPSDT Program under the Alabama Medicaid State Plan who will no longer be eligible for this service upon turning 21, and for whom private duty nursing services continue to be medically necessary based upon approved private duty nursing criteria. The Alabama Medicaid Agency is the Operating Agency for the TA Waiver for Adults. Private Duty Nursing providers will service TA recipients. The Alabama Department of Rehabilitation Services will provide Targeted Case Management to TA recipients.

The TA Waiver providers have a provider enrollment contract with the Alabama Medicaid Agency.

The TA Waiver provider is the payee for all TA Waiver services.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing to Medicaid and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

NOTE:

Private Duty Nursing providers can also enroll to provide services under the Technology Assisted Waiver for Adults (TA Waiver) Program. DXC must have approval from the Medicaid Agency to enroll a Private Duty Provider for the TA Waiver. Providers wishing to add the TA Waiver to their enrollment should submit a letter to DXC requesting to add this specialty. Once received, DXC should forward those letters to the Enrollment & Sanctions Unit for coordination and approval from the program manager of the TA Waiver program.

The effective date of enrollment is the first day of the month in which the written request for enrollment is received.

4.2.8 Alabama Department of Senior Services (ADSS)

(Enrolled as an administering agency/provider for the HIV/AIDS Waiver)

Type

53

Specialty

620 HIV/AIDS

- ADSS has a contractual agreement with the Alabama Medicaid Agency to provide HIV/AIDS Waiver services. ADSS may subcontract with any qualified provider who meets Medicaid's enrollment criteria. ADSS is the payee for HIV/AIDS Waiver services.
- ADSS is the payee for the ADSS HIV/AIDS Waiver Services and no other provider information is added to the DXC file for subcontracting providers.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing to Medicaid and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

4.2.9 Alabama Department of Mental Health/Mental Retardation, Department of Public Health, Department of Youth Services, and Department of Human Resources

(Enrolled as providers for Rehab Option Services)

Type

11

Specialty

118 DHR – Submit provider file update to enroll individuals

DPH – Does not enroll individuals

DYS Rehab Services – Submit provider file update to enroll individuals

111 Mental Health Clinic (DMH) Rehab Services (Has their own enrollment application)

339 Psychiatry – Automatically add the 931 specialty to the provider's file.

860 Substance Abuse

931 Telemedicine Services (Applicable for specialty 339 only).

Each agency has a contractual agreement with the Alabama Medicaid Agency to provide Rehab Option services. The State Agency may subcontract with any qualified provider who meets Medicaid's enrollment criteria. The State Agency is a payee for Rehab Option services.

The State Agency should submit to DXC a completed Provider File Update Request for the providers with which they have subcontracted.

For providers enrolling in Substance Abuse (SA) Treatment Services, the Application Update Form will be submitted along with other forms if applicable which may include: Disclosure Forms, Provider Agreement, Corporate Board of Directors Resolution, and an application fee.

For providers enrolling in Mental Illness (MI) Treatment Services, the online Provider Enrollment portal will be used to submit applications.

- The Provider Enrollment Web Portal will be used to enroll the individual providers with the ADMH for MI Treatment Services (Enrollment Type – Individual Within Group).
- Provider type will be "Mental Health Provider" and specialties added will be Psychiatrist and Telemedicine Services.
- The Group Association section of the online application should include the Department of Mental Health name, NPI, and Medicaid ID.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Only physicians can enroll with the Department of Mental Health. The Department of Mental Health must provide the physician's Social Security Number and physician's medical license number. A copy of the physician's medical degree should be attached along with a copy of the current license. The SSN can be written on the application or a copy attached.

DXC will notify Medicaid within 2 days of the enrollment of new Medicaid providers.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or written, signed request and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

4.2.10 The Alabama Department of Mental Health(DMH) Mental Illness and Substance Abuse Programs, Alabama Department of Youth Services, Alabama Department of Human Resources, Alabama Department of Public Health, Alabama Institute for Deaf and Blind-Field Services, and the Alabama Department of Rehabilitation Services are enrolled as Targeted Case Management (TCM) providers.

Type

21 (Targeted Case Management)
Note: Targeted Case Management is allowed for provider type 11-Mental Health with a current specialty of 860-Substance Abuse. TCM services for these providers are denoted by adding the specialty 113-Substance Use Disorder Care Coordination.

Specialty

113 Substance Use Disorder Care Coordination (ONLY to be used with Provider Type 11— Mental Health with Specialty--860 Substance Abuse)

209 Mentally Ill Adults

210 Care Coordinator for Pregnant Women

211 AIDS/HIV Positive Individuals

217 Foster Child

229 Intellectually Disabled Adults

590 Technology Assisted (TA) Waiver for Eligible Adults

640 Adult Protective Services

650 Disabled Children

Each Agency/organization has a contractual agreement with the Medicaid Agency to provide targeted case management. The state Agency may subcontract with any qualified provider who meets Medicaid enrollment criteria. The state Agency/organization should submit the request for enrollment for TCM services to Medicaid for the providers with which they have subcontracted. Medicaid will forward a provider file Maintenance Form to DXC.

- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

NOTE:

DXC should not process any new TCM providers unless the Maintenance Form is forwarded under OPR.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or written, signed request and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing to Medicaid and must be signed.

4.2.11 The Alabama Department of Public Health (DPH)

(Enrolled as an administering agency/provider for county health department services.)

Type

13

Specialty

021	Cardiac Electrophysiology	023	Sports Medicine
274	Dental Prevention		
318	General Practitioner	94	CRNA
319	General Surgeon	770	Endocrinology
310	Allergist	560	EPDST
313	Cardiovascular Surgeon	600	QMB/EPSDT
314	Dermatologist	83	Family Planning
92	Family Nurse Practitioner	700	Plan First
316	Family Practitioner	550	DPH Lab
317	Gastroenterologist	116	Licensed Social Worker
800	Internal Medicine	323	Neonatologist
326	Neurologist	93	Nurse Practitioner (Other)
325	Neurological Surgeon	100	Physician Assistant
328	Obstetrician/Gynecologist	101	Anesthesiology Assistant
330	Opthalmologist	830	Rheumatology
331	Orthopedic Surgeon	312	Cardiologist
321	Hand Surgeon	750	Colon and Rectal Surgery
333	Pathologist	313	Cardiovascular Surgeon
337	Plastic Surgeon	272	Oral Surgeon
339	Psychiatrist	170	Physical Therapist
338	Proctologist	173	Speech/Hearing Therapist
340	Pulmonary Disease Specialist	171	Occupational Therapist
341	Radiologist	271	General Dentistry Practitioner
90	Pediatric Nurse Practitioner	940	Vaccinations
345	General Pediatrician	190	Optician
320	Geriatric Practitioner	180	Optometrist
324	Nephrologist	810	Orthopedic
630	Nephrology	332	Otologist, Laryngologist, Rhinologist
140	Podiatrist	760	EENT
790	Infectious Disease	329	Oncologist
112	Psychologist		

200 Audiologist

The DPH has a contractual agreement with the Alabama Medicaid Agency to provide county health department services (i.e., EPSDT, family planning, prenatal, preventive health, lead screenings, adult immunizations, home health, hospice, and primary care).

Medicaid will forward copies of the approved contractual agreement to DPH along with instructions for completion of the enrollment process.

The DPH will forward a copy of their contractual agreement with the Medicaid Agency to DXC along with a letter requesting to be enrolled as a Medicaid provider.

DXC will send the Provider Enrollment packet to the DPH for completion of the enrollment process.

The DPH should submit to DXC a completed Provider File Update Request for the providers that they have subcontracted with. DXC will notify Medicaid within 2 days of the enrollment of new Medicaid providers.

In order to add the 274 specialty, the provider should submit a written request along with their certificate of completion. DXC enrollment staff will verify providers completion of the 1st Look training by checking the list provided by ALAAP. Note: This specialty should not be a primary specialty.

If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or written, signed request and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

To Add County Health Department Physicians to the Provider Table

Listed below are the procedures to add a County Health Department physician, to the Alabama Medicaid Provider Table.

A claim is submitted for services rendered by a County Health Department physician who is not on the provider file, the claim fails for Error Status 201 (NPI is invalid, not on file or name/number disagree).

Using the provider master list, furnished by the Department of Public Health, verify that the provider is a valid Health Department physician.

If the physician's name is not on the Health Department's master list nor has a new provider transmittal form been received, delete the claim.

If the physician's name is on the master list, add him/her to the Provider Table.

ECS indicator is always 'y.'

Effective date of enrollment is the first day of the "Assigned" month or issue date of license, whichever is later. End date of enrollment is the expiration date of license with a 45-day grace period.

If a provider with a specialty code of 560, 083 or 181 is added to the provider table, give a screen print to Medical Policy department to add the provider to the Customary Charge Panel.

Let the worksheet recycle.

Name Change

Use the Name Change form or written, signed request.

All Other Changes

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

4.2.12 Alabama Department of Rehabilitation Services (ADRS)

Enrolled as the administering agency/provider for the State of Alabama Independent Living (SAIL) Waiver.

Type

53

Specialty

660 SAIL Waiver

- The ADRS has a contractual agreement with the Alabama Medicaid Agency. The ADRS may subcontract with any qualified provider who meets Medicaid's enrollment criteria.

The ADRS is the payee for all SAIL waiver services and no other provider information is added to the file for subcontracting providers.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or written, signed request and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing to Medicaid and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

4.2.13 Alabama Department of Senior Services

Enrolled as an administering agency/provider for the Alabama Community Transition Waiver.

Type

51

Specialty

661 ADSS ACT Waiver – Effective 4/1/2015

The ADSS has a contractual agreement with the Alabama Medicaid Agency to provide Alabama Community Transition waiver services. ADSS may subcontract with any qualified provider who meets Medicaid's enrollment criteria.

- ADSS is the payee for the Alabama Community Transition Waiver Services and no other provider information is added to the DXC file for subcontracting providers.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or written, signed request and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 and the name change update.

All Other Changes

All other changes must be submitted in writing to Medicaid and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

4.2.14 Rehab - Early Intervention

Type

63

Specialty

960 Rehab-Early Intervention

The Alabama Department of Rehabilitation Services has a contractual agreement with the Alabama Medicaid Agency to provide Early Intervention Rehab services (i.e., speech, physical, occupational therapy, vision, and audiology).

The Alabama Department of Rehabilitation Services may subcontract with any qualified provider who meets Medicaid's enrollment criteria.

Alabama Department of Rehabilitation Services is the payee for Early Interventions Services and no other provider information is added to the DXC file for subcontracting providers.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement Form and attach a new W-9.

All Other Changes

All other changes must be submitted in writing to Medicaid and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

4.2.15 Residential Treatment Facilities

Type

01

Specialty

013 Residential Treatment Facilities

Policy:

Residential psychiatric services for recipients under age 21 are covered services when provided by a psychiatric facility which is accredited by The Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), and the Council on Accreditation of Services for Families and Children (COA), or by another accrediting organization with comparable standards that is recognized by the State. All residential treatment facilities (RTFs) requesting enrollment must be under contract with one of the state agencies (DHR, DMH, DYS) who place children in residential settings. The state agency contracting with a certified RTF shall be responsible for collecting all the documentation required for enrollment and forwarding the packet to Medicaid for approval.

Enrollment Procedure:

1. The state agency requesting enrollment for a certified RTF shall forward the enrollment packet to the Associate Director of Institutional Services. This packet shall contain the following documents:

   Evidence of RTF accreditation from The Joint Commission, CARF, COA, or another accrediting organization with comparable standards that is recognized by the State;

   a. Evidence of compliance with Title VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975;
   b. A contract or placement agreement between the RTF and the respective state agency to provide RTF services in the State of Alabama;
   c. A provider application from the RTF to participate in the Medicaid program;
   d. A written description of an acceptable Utilization Review plan currently in effect in the RTF;
   e. A written attestation of compliance with the requirements of 42 CFR, Part 483, Subpart G, regarding the reporting of serious occurrences and the use of restraint and seclusion in the RTF;
   f. Evidence of compliance with staffing and medical record requirements necessary to carry out a program of active treatment for individuals under age 21;
   g. A budget of costs for the RTF's initial cost reporting period; and
   h. A completed Provider File Maintenance Update Form.

2. A program file will be established for each RTF enrolled with Medicaid. Copies of all relevant documentation will be maintained in the Institutional Services program area.
3. The Associate Director will review the packet contents to determine if all the required documents have been submitted and meet the requirements as noted in the Conditions of Participation in Chapter 41 of the Administrative Code.
4. The budget of costs will be forwarded to Provider Audit for review in order to establish an interim rate for the RTF. The auditor will return the rate information to the Associate Director so that the rate can be loaded to the Provider NH/IP Rates panel when the enrollment information is sent to DXC.
5. The Associate Director of Institutional Services will forward the Provider File Maintenance Update Form and the established rate to DXC Provider Enrollment through the Agency tracking system.
6. DXC will return the Provider File Maintenance Form to the Associate Director of Institutional Services upon completion of the enrollment process, including loading the established rate to the Provider NH/IP Rates Panel. The Associate Director will forward a copy of the form to the state agency that initiated the enrollment. The enrollment effective date will normally be the date of the contract from the state agency.
7. DXC will direct all inquiries regarding RTF enrollment to the Associate Director of Institutional Services.
8. If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
9. If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Provider notifies contracting state agency. The contracting state agency will notify DXC. Use the Name Change form or written, signed request and attach a current W-9.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing to the contracting state agency.

Out-of-State Non-Bordering Providers

Enrollment is not applicable for this provider type.

4.2.16 PACE – Program of All-Inclusive Care for the Elderly

Type

64 (PACE Organization)

Specialty

645 (PACE)

Policy:

The Alabama Medicaid Agency is the administering agency for the PACE program.

Enrollment Procedure:

PACE Organizations must be approved by CMS and AMA to participate as a PACE Organization.

The PACE Organization will receive a monthly global fee for each participant enrolled in the PACE program. The PACE Organization will receive the monthly global fee minus the patient liability when a participant enters a nursing home. All claims for any other provider for a PACE participant will be denied.

If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Providers must submit the Change of Ownership (CHOW) form, new provider agreement, new disclosures, new W-9, and new EFT form.

Note: CMS and AMA must be notified within 14 days prior to the effective date of the change of ownership.

Name Change

Use the Name Change form, or a written, signed request and attach a current W-9 form.

Note: CMS and AMA must be notified within 14 days prior to the effective date of the change of name.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing to CMS and AMA. All other requests must be signed by appropriate PACE Organization officials.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

4.3 PATIENT 1ST ENROLLMENT PROCEDURES FOR PHYSICIANS, GROUPS AND CLINICS

A Medicaid enrolled individual physician or physician group practice may become a Patient 1st Primary Medical Provider (PMP) if the physician or group routinely practices in the field of general practice, family practice, internal medicine, or pediatrics. Federally recognized clinics such as FQHCs or RHCs may also enroll in the program as a PMP. The effective date of enrollment for a PMP (clinic/group/individual) should be the first of the month in which the application is processed for enrollment by DXC staff.

Variations to the above must be coordinated with the Agency.

Enrollment

General Instructions

1. Patient 1st Applications, Agreements and any completed Agreement Attachments must be completed in black ink only and must contain original signatures and original initials where applicable. Patient 1st Applications, Agreements and any completed Agreement Attachments cannot be faxed. In addition, check the Patient 1st enrollment forms to ensure the following information is contained:

2. **SECTION I**

   a. Indication should be made of whether the applicant is enrolling as a (n) Individual, Group, Clinic, FQHC or RHC.

   b. Indication of Yes or No should be made of whether the practice or associated persons participating as a PMP has been sanctioned or terminated by either the Medicaid or Medicaid Program. If “Yes” is indicated, ensure that supporting documentation is supplied with the application. A packet containing such information must be forwarded to Program Integrity for review prior to completing the enrollment process.

   c. Indication of the specialty for the participant should be made by marking a specialty listed. The space marked as “Other:” is to allow the specialty of particular specialists to indicate his/her type and specialty. The enrollment of a provider with a specialty other than those listed requires Agency approval.

   d. Indication of Yes or No should be made of whether the provider is a/is associated with a teaching facility at the site to which this enrollment applies.

   e. Indication of the name of the enrolling provider (individual, group, clinic, etc.) should be made in this section. The name listed should be consistent with the manner in which the provider is enrolling (individual, group, clinic, etc.).

   f. Indication of the provider NPI number assigned to the enrolling provider should be made in this section. The provider NPI number indicated should be applicable to that assigned to the provider name indicated and should be the NPI number applicable to the practice site indicated.

g. Indication of the group/clinic/FQHC/RHC name should be made in this section. The name listed should be consistent with the manner in which the provider is enrolling (group, clinic, FQHC or RHC name).

h. Indication of the provider NPI number assigned to the enrolling group/clinic/FQHC/RHC should be made in this section. The provider NPI number indicated should be applicable to that assigned to the provider name indicated and should be the NPI number applicable to the practice site indicated.

i. Indication of the person to be contacted regarding Patient 1st should be made in this section.

j. Indication of the phone number where the Patient 1st contact can be reached should be made in this section.

k. Indication of the physical address of the service site should be made in this area.

l. Indication of the mailing address at which the PMP would like to receive Patient 1st mailings should be made here. This address should be provider's mailing address. This address should be applied to the Provider Locations Name Address Panel for the enrolling provider.

NOTE:

If the application is for a clinic or group, the mailing address must be updated on the file of clinic or group as well as the individuals associated to the clinic or group. If the application is for an individual, who is associated to a clinic or group, the mailing address must be updated on the clinic or group file, the individual's file and all other providers associated to the clinic or group.

SECTION II

a. Indication of the county name for which the PMP is enrolling should be indicated in the first column of the table.

b. Indication of the number of patients the PMP would like to have assigned from each county should be indicated in the second column of the table.

NOTE:

Max caseload calculations are based on the PMP serving as a FTE, meaning the PMP practices at the location for a minimum of 32 hours per week.

MAX CASELOAD: The maximum caseload a PMP can serve collectively is 1200 patients unless utilizing physician extenders. PMPs utilizing physician extenders may have an additional 400 patients per physician extender utilized. The overall max caseload for a PMP is 2000. Enrollments of PMPs requesting a caseload of more than the maximum allowed should be coordinated with the Agency.

MINIMUM CASELOAD: The minimum caseload a PMP can serve collectively is 25 patients. Enrollments of PMPs requesting a caseload of less than 25 patients should be coordinated with the Agency.

c. Indication of the Patient Age Criteria for the patient assigned from each county should be indicated in third column of the table. Assume no specific age. Leave 000-999. If a provider states that they only want newborns, then indicate 000-000. This criterion is determined by "through" logic.

d. Indication of YES or NO regarding the PMP's wish to be published in the Patient 1st List should be indicated in the fourth column of the table for each county in which the PMP is enrolling.

e. If the physician employs a mid-level practitioner(s)/physician extender(s), the name(s) and NPI number(s) for up to two (2) should be listed in this section. The provider NPI number(s) indicated should be associated to the site of practice to which the patients will be assigned.

NOTE:

For each mid-level practitioner (up to two), an additional 400 patients may be added for the specific location. For private providers, a maximum of 2,000 is allowed. (Refer to maximum caseload standards above for additional instructions.)

f. Indication of YES or NO should be made as to whether the enrolling physician/clinic has admitting privileges. If YES is indicated, the name of the hospital at which the PMP has privileges should be given. If NO is indicated Attachment A (Patient 1st Hospital Admitting Agreement) of the contract must be completed.

g. Indication of YES or NO should be made as to whether the PMP will be performing his/her EPSDT screenings. If YES is indicated, verify that the PMP is enrolled in the EPSDT program for the location the patients will be assigned. Also verify that the provider has a CLIA number on file. If NO is indicated, verify that provider is not enrolled in the EPSDT program. If not performing EPSDT screenings Attachment B (EPSDT Agreement) of the contract must be completed. Indicate a specialty type 820 if the PMP is not and does not wish to enroll as an EPSDT screening provider.

h. Indication of 24-Hour Access phone number and the description of the after-hours coverage should be made in this section. The number is not required to be different from office phone. A description of the after-hours coverage is required.

i. Indication of the number of hours per week the PMP practices at the location to which this application applies should be made in this section. The PMP practice must be open a minimum of 32 hours per week and the PMP must practice at the location a minimum of 32 hours per week to be considered a FTE (Full Time Equivalent). If less than a FTE, a percentage of a total patient caseload will be allowed, based on availability.

SECTION III

a. Indication of all physicians/practitioners and provider NPI numbers associated to this clinic site should be made in this section.

b. Indication of the provider NPI numbers assigned to the individual providers should be made in this section. The numbers indicated should be the number assigned for that provider which is associated to the enrolling clinic/group.

c. Indication of the hours per week which the physician or practitioner will be working at the site should be made in this section. (This information will be used to determine FTE status.)

d. Indication of whether the provider listed is a physician or a practitioner should be made in this section.

For Clinics Only: To determine panel size:

- For every FTE physician minimum (32 hours a week), 1,200 patients will be allowed. If the physician is not a FTE, then a percentage of patients will be allowed based on on-site availability. For example, if the physician is a .5FTE, then a caseload of 600 will be allowed.
- If there is midlevel practitioner participation, then an additional 400 patients per midlevel (up to 800 total) will be allowed. The same FTE criteria will apply to midlevel practitioner participation.
- Physicians and/or midlevel practitioners must be a minimum of .2FTE to carry or extend a caseload.
- If the clinic is an IRHC run by a nurse practitioner, then the clinic can have a maximum caseload of 1,200.
- Only the clinic number is to be enrolled – not the individual providers.
- The Provider Contract Panel should be checked to ensure that the individual doctors are not enrolled as PMPs. If a doctor in the group is enrolled as an active individual PMP, the clinic should be contacted to determine further action.
- The individual specialty of the individual physicians should be checked to correspond to the age requirement specified by the clinic.

For Groups: Group providers can be enrolled with the permission of the Agency. To determine panel size:

- For every FTE physician minimum (32 hours a week), 1,200 patients will be allowed. If the physician is not a FTE, then a percentage of patients will be allowed based on on-site availability. For example, if the physician is a .5 FTE, then a caseload of 600 will be allowed.
- If there is midlevel practitioner participation, then an additional 200 patients per midlevel (up to 400 total) will be allowed. The same FTE criteria will apply to midlevel practitioner participation.
- Physicians and/or midlevel practitioners must be a minimum of .2 FTE to carry or extend a caseload.
- Only the group number is to be enrolled – not the individual providers.
- The Provider Contract Panel should be checked to ensure that the individual doctors are not enrolled as PMPs. If a doctor in the group is as an active individual PMP, the group should be contacted to determine further action.
- The individual specialty of the individual physicians should be checked to correspond to the age requirement specified by the group.

AGREEMENT INSTRUCTIONS

Page 1

- Indication of the name of clinic/group/individual provider enrolling should be made in this space. (This name should be consistent with that indicated on the Patient 1st application.)
- Indication of the name of the city in which the provider's practice is located should be made in this space. (The name of the city should be consistent with the name of the city indicated as part of the physical location on the Patient 1st application.)
- Indication of the county in which the provider's practice is located should be made in this space.
- Indication of the state in which the provider's practice is located should be made in this space. (The name of the state should be consistent with the name of the state indicated as part of the physical location on the Patient 1st application.)

Page 9

- Enrollment staff should indicate the effective date. This date should be consistent. The name of the Enrollment staff member who processed the application/agreement should be indicated. At a minimum, the person's first initial and last name should be indicated.
- The signature of the enrolling PMP should be indicated in this space. This signature must be an original and must be consistent with the signature provided on the Patient 1st application. If enrolling as a clinic or group, the signature must be an original signature of an authorized representative and must be consistent with the signature provided on the Patient 1st application.
- The provider's NPI should be indicated. The number indicated in this space must be consistent with the provider's NPI number indicated on the Patient 1st application.

Patient 1st Hospital Admitting Agreement (Attachment A)

- This form should be completed, only if the clinic/group/individual provider has indicated the absence of hospital admitting privileges. (To determine if there is an absence of hospital admitting privileges refer to the statements regarding hospital admitting privileges in Section II (continued) of the application and the fifth bullet of Attachment C of the Agreement.) If the clinic/group/individual provider does not have admitting privileges this form must be completed in its entirety. The information indicated on this form should pertain to the physician or group agreeing to cover hospital admissions for the enrolling PMP. The provider name and NPI must be verified.

NOTE:

Original signatures required. If an individual is covering hospital admission, the signature must be that of the individual. If a clinic/group is covering hospital admission, the signature must be that of an authorized representative for that clinic/group.

EPSDT Agreement (Attachment B)

- This form should be completed, only if the clinic/group/individual provider chooses to utilize an EPSDT Screening Designee. (To determine if the PMP is choosing to utilize an EPSDT Screening Designee refer to the statements regarding EPSDT in Section II (continued) of the application and the first bullet of Attachment C of the Agreement.) If the clinic/group/individual provider chooses not to perform EPSDT screenings and intends to utilize an EPSDT Screening Designee, this form must be completed in its entirety. (This form is **not** an EPSDT Agreement to be used to enroll a provider in the EPSDT Program.)

NOTE:

Original signatures required. If the applicant is enrolling as an individual, the PMP signature must be that of the individual. If enrolling as a clinic/group the signature must be that of an authorized representative for that clinic/group. Signatures indicated on Agreement Attachments must be consistent with that indicated on the Application and the Agreement.

If the Screener/Designee is an individual screener the signature must be that of the individual. If the Screener/Designee is a clinic, such as a health department, the signature must be that of an authorized representative for that clinic.

Components of Monthly Fee (Attachment C)

- This form should be completed to show the components in which clinic/group/individual provider intends to participate. Indication of initials shows the component is one in which the clinic/group/individual provider intends to participate. This form will be utilized to determine the Monthly Case Management Fees.

NOTE:

Original initials are required. If enrolling as an individual, the initials must be that of the individual. If enrolling as a clinic/group the initials must be that of an authorized representative for that clinic/group. Initials indicated on this Agreement Attachment must be consistent with the initials for the signatures indicated on the Application and the Agreement.

- EPSDT – If initials are indicated, the enrolling clinic/group/individual provider file must contain an active 560 specialty or must enroll as an EPSDT screener. Otherwise, this component must be corrected.
- VFC – If initials are indicated, the enrolling clinic/group/individual provider file must be a VFC provider or must enroll as a VFC participant. Otherwise, this component must be corrected.
- 24/7 Coverage – If initials are indicated, the enrolling clinic/group/individual provider file must indicate on the Application, a phone number as description of afterhours coverage.

Medical Home Project – Agency staff will notify EE of the approval of a provider's participation in this component.

- Hospital Admitting Privileges - If initials are indicated, the enrolling clinic/group/individual provider file must indicate on the Application, the hospital privileges information or must submit a completed Attachment A. Otherwise this component must be corrected.
- Electronic Notices - If initials are indicated, the enrolling clinic/group/individual provider file must choose to receive electronic notices. Otherwise, this component must be corrected.
- Electronic Education Materials - If initials are indicated, the enrolling clinic/group/individual provider's PMP Special Condition Panel should be updated.
- Life State Management - If initials are indicated, the enrolling clinic/group/individual provider's PMP Special Condition Panel should be updated.
- InfoSolutions - If initials are indicated, the enrolling clinic/group/individual provider's PMP Special Condition Panel should be updated.

Notification

A letter or copy of the PMP's disenrollment request containing the DXC action stamp indicating what action was taken should be returned to the disenrolling PMP.

Changes To The Provider Information Panel For Patient 1st PMPs

Disenrollment of Patient 1st Providers

3. Requests for disenrollment should be sent 30 days prior to the date of disenrollment and must be mailed or faxed correspondence. The request must specify the date in mm/dd/yy format. If the date is not indicated, the PMP should be contacted and written documentation containing the date should be obtained. In addition, specific instructions must be given in the written request in regards to the auto-assignment or reassignment of patients. If specific instructions are not given, the PMP should be contacted and written documentation containing the specific instructions should be obtained.

File Action

- For future disenrollments, the provider file should be end-dated to reflect the last day of the month in which the PMP is requesting disenrollment. If the PMP is requesting a middle of the month date, then the end date should reflect the last day of the preceding month.
- In cases where the PMP has already left, the disenrollment should be reflective of the last day of the month proceeding the month in which the PMP left or quit practicing.
    - If a PMP has indicated that he/she is closing the practice, the appropriate action should be taken to end date the appropriate Provider Panels as well as the Provider Information Panel and Provider Special Condition Panel. If a specific date and auto assignment/reassignment instructions are not given the PMP should be contacted and documentation containing the specific date and auto assignment/reassignment instructions should be submitted via fax or mail.
    - When a PMP leaves a group, the appropriate action should be taken to end date the appropriate Provider Information Panel as well as the PMP

Special Condition Panel. If a specific date and auto assignment/reassignment instructions are not given or it is uncertain whether the PMP is leaving the group, the group should be contacted and documentation containing the specific date, status of the PMP and auto assignment/ reassignment instructions should be submitted via fax or mail. In the case of a PMP leaving a group, the group may decide to have the patient reassigned to another PMP within the group.

- If a provider has sent notification of disenrolling from the Patient 1st Program the PMP Special Condition Panel should be closed. In addition to updating the PMP Special Condition Panel, the PMP specialty indicator of 820 (if present on file) and should have an end date entered. If a specific date and auto assignment/reassignment instructions are not given the PMP should be contacted and documentation containing the specific date and auto assignment/reassignment instructions should be submitted via fax or mail.
- If a provider has sent notification to disenroll from a specific county or counties for which the provider was participating in for Patient 1st, only those county segments on the PMP Special Condition Panel should have an end date entered. No changes should be made to the provider file. If no date or auto assignment/reassignment instructions were given, the PMP should be contacted and documentation containing the specific date and auto assignment/reassignment instructions should be submitted via fax or mail.

Patient Reassignment

- The termination date applied during the run of the report should be reflective of the end date applied to the PMP's file. (As applied to the PMP Special Condition Panel and the Provider Information Panel, if the date is within the middle of the month, then the date should be reflective of the last day of the month preceding the month in which the PMP left or quit practicing.)
- If the PMP is leaving a group practice, then the patients should be reassigned to a member of the group. If the letter does not specify what group member, the PMP, group or clinic should be contacted to determine to whom the patients should be assigned. Written documentation should be submitted stating the specific action and designee.
- For all reassignments, please verify that the new PMP has an adequate panel size **and** is enrolled for all counties for which the current PMP has patients assigned. If the new PMP does not have an adequate panel size and/or is enrolled for all counties, the new PMP should be contacted to see if he/she would like to increase the panel size and/or enroll for that county. **If the answer is yes, written documentation, containing specific instructions, is required as permission to make needed changes. This documentation may be submitted via fax or mail. If the answer is no, then all patients must be put back through auto assignment, again based on written documentation containing specific instructions is required.** If the reassignment will exceed caseload standards, then the Agency should be contacted for further instructions.

File Changes

- Provider Service Location Change: If a PMP has requested a new service location, a new Patient 1st application and agreement is required for the provider to participate as a PMP under the location. If the PMP intends to close the old service location, the patients should be transferred from the service location to the new service location. To make such a change, written documentation is required and may be submitted via fax or mail. If a specific date and transfer instructions are not given, the PMP should be contacted to obtain a written request containing the specifics. If the PMP is leaving a group, the group may decide the reassignment of patients.
- Request to decrease/increase caseload of a PMP must be submitted in writing via fax or mail. The request must specify the counties and the specific decrease/increase to occur. If the PMP indicates no new patients should be assigned, the provider's Patient 1st-Region Enrollment Maintenance record is updated to Panel Hold=Yes. If the PMP wants to limit new assignments to "Last PMP", Newborns or Sibling assignments as Max Caseload Cap of 1 should be placed on the segment for the specified county or counties.
- Provider Status 'C" (Provider Cancelled per Request) - Check the screen to see if the provider is an active PMP. If the request does not specify, the DXC Provider Enrollment Unit should contact the PMP to determine what should be done with the patients. (Steps related to file closure that are outlined above should be followed at that point.)
- Provider Status 'P' (Deceased Provider) – Follow processes as outlined for a Provider Cancelled per Request closure
- Provider Status "B' (Bad Address) - Check the Provider Information Panel to determine if the provider is an active PMP. If yes, DXC's Provider Enrollment Unit should contact the PMP to request that the provider submit their change of address information**. The file should be pended for one month**. If after 30 days, the PMP has not complied with the request, patients should be put through the auto assignment process. The PMP should be notified of the action taken.
- Provider Status 'D' (Contract Expired) - Follow processes as outlined for a Provider Cancelled per Request closure.
- Provider Status 'S' (Fraud and Abuse Providers) - Check the Provider Information Panel to determine whether the provider is an active PMP. If yes, patients should be put back through auto assignment. The end date applied to the provider file should reflect the end of the month proceeding the month in which the provider was sanctioned. Case management payments should be recouped from the month in which the PMP's sanction became effective.

If a situation arises that cannot be resolved by the above, instructions should be coordinated with the State. The inherent need in any disenrollment is to ensure that patients are not left assigned to a physician that may no longer be practicing. If it is questionable, contact the State for instructions.

4.4 PROVIDER REENROLLMENT PROCEDURES

CMS Federal Requirement 455.414 requires that all providers reenroll at least every five years. In order to meet these federal requirements, the following procedures for reenrollment will be accomplished.

Providers who are required to reenroll will be sent a notification letter instructing them to access the secure provider portal and download the Provider Reenrollment Facsimile (PRV-A-035-M). Providers will review the Provider Enrollment Facsimile and make any corrections on the document and sign. Any additional documentation required to include the Provider Agreement and Disclosure forms are mailed with the facsimile to Provider Reenrollment for processing. The following actions will occur by the reenrollment staff to process the reenrollment applications:

The file clerk will:

- Enter the received date in the “Date Response Received” field on the Enrollment Info Panel.
- Log the application on the Reenrollment Log with the NPI and Provider name entered on the application and date received.
- Scan the application into the Feith database. Feith will auto assign the applications to the clerks based on the number of clerks available.
- Forward the original applications to the assigned clerks.

The assigned rep will:

- Run database checks in Accurint (LexisNexis). A PDF copy of the search results should be saved and appended to the scanned copy of the Reenrollment application.
- Verify the provider’s licensure information with the appropriate licensure board if the Accurint database check did not validate the provider’s license. The states’ licensure boards information is located on the provider rep drive in the Reenrollment folder. A PDF copy of the verification should be appended to the scanned provider file.
- Verify the NPI with the NPPES registry if the Accurint database check did not validate the provider’s NPI. A PDF copy of the verification should be appended to the scanned provider file.
- Verify the Medicare number in PECOS and enter on the provider file.
- If CLIA information is added or changed, verify that the CLIA information entered on the application matches the copy of the CLIA certificate submitted by the provider.
- If DEA information is added or changed, verify that the DEA information entered on the application matches the copy of the DEA certificate submitted by the provider.
- Enter any new specialties indicated on the application. If the provider is adding EPSDT or Plan 1st as a specialty the appropriate agreement must be submitted. Provider must have a CLIA on file if adding the EPSDT specialty.
- Verify that all disclosure questions on the applicable disclosure form were answered. If any question was answered “yes” the application should be forwarded to Program Integrity for review. The Feith workflow should be updated to a status of Agency review.

- Verify that contact information was entered. A contact name and phone number is required. The contact can be the same as the provider.
- Verify that the provider submitted a signed and dated provider agreement. The application must be signed by the provider, not a designee. Contact the provider by telephone if the signature is not the provider's signature or if the agreement was not sent. If unable to contact the provider by telephone send the "Corrections Needed" letter to the provider. Enter a note in Feith with the corrections needed. A copy of the corrections letter should be added to the scanned copy of the application in Feith. Sample letter is on Provider Rep drive in Reenrollment folder.
- Contact the provider if any of the above information (other than signature) is not submitted or submitted incorrectly. Advise the provider to fax any faxable documentation. A note should be entered into Feith indicating the date the provider was notified of needed corrections and the requested corrections. Review the submitted faxes to determine requested corrections were made. The fax should be maintained with the provider file. A copy of the fax should be given to file clerk to scan and add to the scanned application.
- Contact provider if requested corrections are not received within the required time frame. Verify that a site visit has been performed by Medicare within the last 12 months or by the Provider Reps for moderate and high risk provider types. If the site visit was performed by the Provider Representatives a copy of the site visit checklist and photographs should be appended to the scanned reenrollment application. If the site visit was performed by Medicare append a copy of the PECOS screen shot to the scanned reenrollment application. NOTE: if no visit is documented, review the file but do NOT finalize the reenrollment.
- Finalize the reenrollment in interChange when the application has been reviewed and all required documentation or corrections, if any, have been received. Finalize the application by accessing the Enrollment Info panel and changing the "Last Enrollment Date" to the date the application was finalized. Finalize the application in Feith workflow with the date the application was finalized.

Providers Disenrolled due to failure to submit Reenrollment

If a provider has been closed due to failure to submit the reenrollment they will have a 30 day "grace period" to submit the reenrollment.

If the provider calls within 30 days of the disenrollment date, Reenrollment will reopen the provider contracts with an end date that is 30 days from the DISENROLLMENT date (not 30 days from the date they contacted reenrollment). The provider will have to submit the reenrollment documents within the 30 day grace period. If the provider fails to submit the reenrollment the file will be closed due to the end date on the provider contracts.

If the provider file is closed again, there will not be an additional grace period and the provider will have to submit a new enrollment through the Provider Enrollment Web Portal.

4.5 DATABASE CHECKS

DXC staff will access the LexisNexis web portal to perform the following database checks prior to enrollment and re-enrollment:

- List of Excluded Individuals/Entities (LEIE)
- Excluded Parties List System (EPLS)
- Social Security Administration Death Master File
- National Plan and Provider Enumeration System (NPPES)
- Licensure board databases
- Verification of Social Security Number or Employer Identification Number

These database checks will be performed for providers and any owners, agents, or managing employees that are listed on the enrollment application. Provider enrollment staff will review the LexisNexis results for these database checks. If no negative findings are detected, the enrollment process will proceed. If negative findings are detected, the enrollment/re-enrollment application will be routed via Feith Workflow to the Alabama Medicaid Program Integrity Unit for review. Program Integrity staff will access the report in Feith Workflow, review the materials, and document their decision in the Feith application which will instruct DXC enrollment staff on how to proceed. DXC enrollment staff will be notified via Feith Workflow that a Program Integrity decision has been reached and will either enroll or deny the application based upon Program Integrity's instructions. A LexisNexis screen-print or report copy will be added to the provider record in the Feith Document Database.

In addition to the above database checks, DXC enrollment staff will also access the Provider Enrollment, Chain and Ownership System (PECOS) for provider types designated as moderate or high risk. This database will indicate whether Medicare has conducted an on-site visit within the past 12 months. If a visit was conducted by Medicare, the enrollment process will continue. If a visit was not conducted by Medicare within the last 12 months, the enrollment application will be staged and a notification will be sent to DXC staff to conduct an unannounced site visit.

The above described database checks are all performed manually. On a monthly basis, all providers, owners, agents, and managing employees will be checked against the EPLS and LEIE databases in an automated process.

4.6 PROVIDER INFORMATION TO COLD

The Provider Information to COLD Enhancement will allow provider enrollment documents to be available in an electronic format via Feith Document Database (FDD), which is part of the Feith System utilized by the State and DXC. An upgrade to a new version of Feith is in place in order to accommodate the usage of the Workflow software and the more advanced capabilities offered in the new version. Eight DXC jukebox platters are used to store the existing Provider Enrollment documentation within FDD. The transition from paper to electronic storage of files has been completed and now the Agency has access to provider paper files that have been inactive during the past six years.

New Documents to FDD

New provider documents received on an ongoing basis are prepped, scanned, processed and stored in FDD by the staff of the Provider Enrollment unit. A high-speed scanner is in place in the unit's area for this purpose.

When prepping the newly received documents, all binding devices and staples are removed and the files are cleared of any unnecessary documents (See Exhibit 1, Item 1a). Copies of thin and colored paper are made when necessary, to enhance the legibility of the document (Exhibit 1, Item 1b). Documentation is stamped to show the receipt date and logged on the Mail Receipt spreadsheet. Pages within the documents that require an original signature are stamped as "original" so that staff working from an image knows the original signature requirement has been met. If the signatures are not original the page requiring an original signature is not stamped. Separator sheets are then placed between each set of documents within the batch and scanned along with the documents to indicate any break in the document type (Exhibit 1, Item 2). Indicating such breaks in the batch allows the scanner to recognize when a new image file should be created.

At this point, the document images enter a FDD Working bin (Exhibit 1, Item 3a) under the control of a work process control tool from Feith called Workflow iQ (Exhibit 1, Item 3b). Workflow is an application that provides control of the flow of work through the Provider Enrollment unit. It allows the documents to be distributed to enrollment staff at the discretion of the supervisor or an appointed staff member. While the documents are under the control of Workflow, the documents are checked for quality and processed with the appropriate action required such as the assignment of a service location for a new application or updating a physician's license on the AMMIS. Documents failing this inspection are rejected from Workflow and rescanned (Exhibit 1, Item 3c.). Documents, which are incomplete or otherwise not valid, are Returned To the Provider (RTP'ed). Images associated with such paper files are deleted from the Working cabinet. Searchable fields are completed during the Workflow processes such as the provider NPI number, first five characters of the provider's last name, date of processing, and document type. Once the document has completed the appropriate processing, it is released from Workflow and moved from the Working cabinet to the Provider Enrollment document cabinet with the archived files and then is available for retrieval in FDD (Exhibit 1, Item 4).

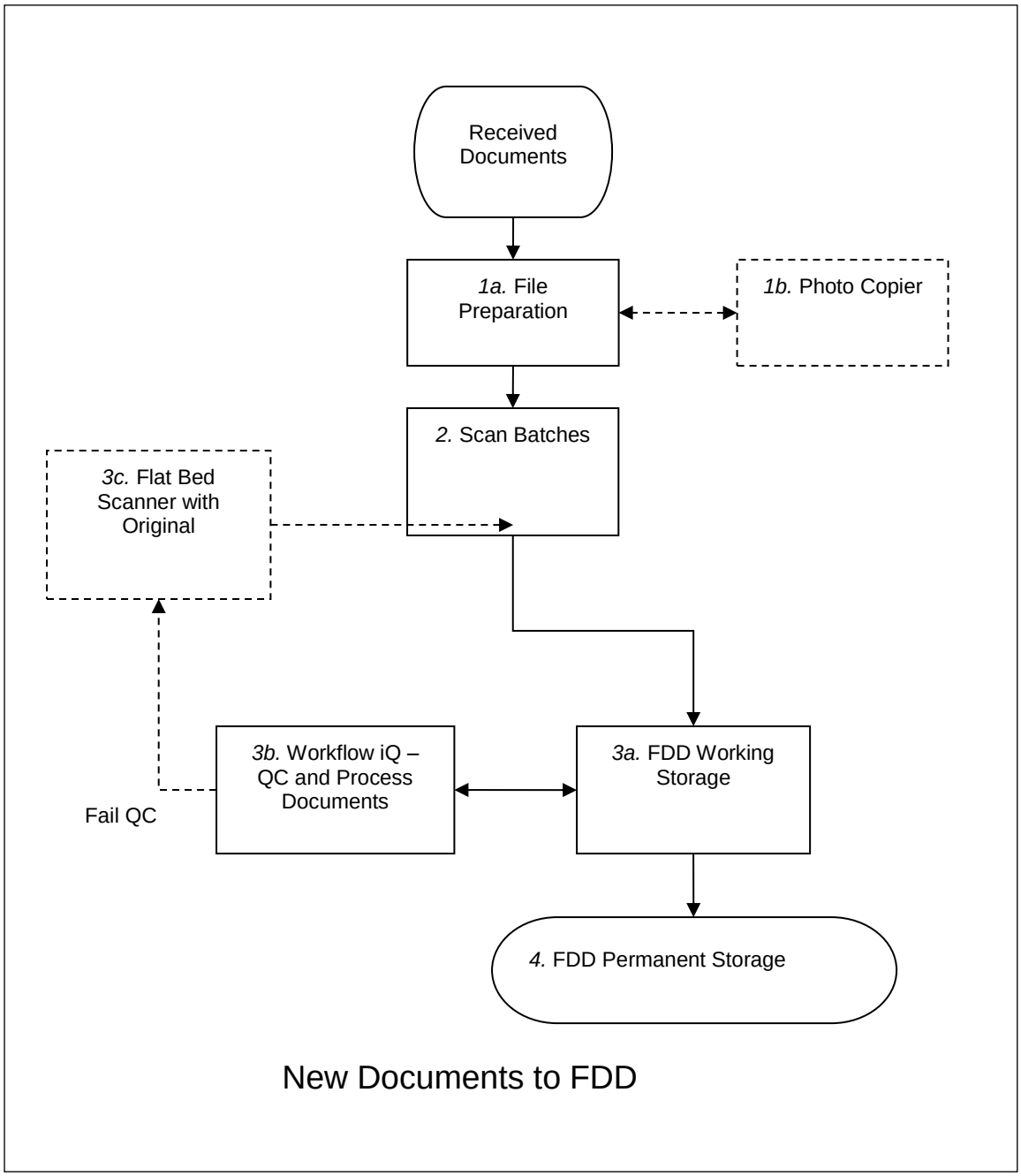

Exhibit 1

Retrieval of All Documents Within FDD

The searchable fields available to use when retrieving a document in FDD are provider NPI number, first five letters of the organization or individual's last name, date, and document type.

NOTE:

The searchable fields available to use when retrieving documents scanned prior to implementation of NPI are provider number, partial provider last name, date and document type.

The primary field to use when performing a search is the provider NPI number, since this is the most specific data element associated with the images. By using the provider NPI number alone, all images associated with the provider NPI number will be retrieved. Using search criteria that is less specific will allow for a range of documents to be retrieved, whereas search results can be improved by adding more specific criteria in the searchable field areas associated with the Provider Enrollment cabinet. Below are some examples of the search criteria that can be used and the results that will be displayed:

1.) Enter the provider NPI number and the document type of "A". Select the search option. By entering such search criteria, only the applications associated with the indicated provider NPI number will be displayed.
2.) Enter the date and the document type of "U". Select the search option. By entering such search criteria, only the updates associated with the date entered will be displayed.
3.) If the provider NPI number is not known, the first five characters of the provider last name is a searchable field. However, by utilizing only this field, several documents may be returned due to the first five characters being a less specific search criterion.

Back Up of FDD

The FDD database is backed up nightly. A backup of the Sun production box is made every week during cycle. The data is then shipped offsite for Disaster Recovery Assistance (DRA). When the platter used to store the images in FDD becomes full, the platter is then backed up. The backup platter is then sent off site for DRA. It takes approximately 2.5 weeks to fill a backup platter.

4.7 PROVIDER BULLETIN

The Technical Writers and the State are responsible for writing and producing bi-monthly provider bulletins. The following steps identify the process of producing the bulletin:

1. Prepare an initial copy by soliciting input from the Agency and DXC staff.
2. Submit articles to the Documentation Specialist for draft preparation.
3. After the draft has been prepared, proof the draft. Repeat steps 2 and 3 as necessary.
4. Complete an DXC Correspondence Tracking form. The form can be found in the Share2/Forms - DXC Alabama Title XIX Provider Services directory on the DXC LAN.
5. Submit the form and the draft to the appropriate personnel at the Agency.
6. Receive changes and, if necessary, revise the draft and submit the revised draft to the Agency.
7. Obtain approval from the Agency.
8. Print the Provider Bulletin materials.
9. Distribute the Provider Bulletin to providers, Alabama Medicaid, and others specified by the Agency.

   > Distribution must occur within ten business days of the Provider Bulletin approval by the Agency.

10. Notify the Web administrator of the location on the LAN of the Provider Bulletin. The Web administrator posts the Provider Bulletin to the Alabama Medicaid Website— *http://www.medicaid.alabama.gov/*

5 PROVIDER REPRESENTATIVE

The Provider Relations representatives are a vital part of the Provider Relations team. The representatives work as liaisons between the Alabama Medicaid Agency and the provider community to assist providers with billing, training, and electronic claims submission. Through personal contact with providers during workshops and onsite visits, the representatives give assistance in claims submission, filing of claims, electronic claims submission, and general Medicaid billing information.

5.1 PRIMARY TASKS

The primary tasks for the Provider Representatives are as follows:

- Assist the Agency in accomplishing its goals and objectives.
- Assist the provider in securing prompt and accurate payment for covered Medicaid services provided to eligible Medicaid recipients.
- Secure prompt and accurate answers to provider inquiries.
- Educate providers on Medicaid billing procedures.
- Market ECS to providers.

A provider representative must have a broad knowledge of all areas within DXC and how the various departments operate. A provider representative must have an in-depth knowledge of all their specific programs and how they function. All provider representatives must have a working knowledge of the following:

- Managed Care programs
- ECS options
- Claims Processing procedures
- Claim Completion Instructions
- EPSDT program
- Eligibility verification procedures (Including knowledge of how to use all DXC eligibility verification devices).
- Prior authorization procedures
- Remittance Advices
- Medicaid forms
- HIPAA
- NPI

5.2 PROVIDER REPRESENTATIVE OPERATIONAL PROCEDURES

A Provider Representative is the liaison between the Alabama Medicaid Agency and DXC. In this role, the Provider representative conducts on-site provider visits, presents workshops and training sessions, markets the PES software, and attends various provider conferences. A provider representative also handles the more complicated provider inquiry issues. The Provider Representative is also responsible for the following:

Marketing Electronic Claims Submission to increase the number of claims received electronically.

Monitoring reports to provide outreach to new providers, evaluate reimbursement amounts, and check to see if an abnormal number of claims deny in a check write.

Contact providers with large numbers of RTPs (Return claims to provider) to see if assistance in claim form completion is required.

Perform in depth research for providers. This research may include a complete review of provider's accounts receivable report, a recap of claim denials over several months for providers, or research on claims processing guidelines.

5.2.1 Annual Provider Training Plan

On an annual basis, the Provider Relations Representative manager and supervisor meet with appropriate Agency staff members to discuss the direction the Provider representatives should take in the upcoming year to effectively train providers and provide outreach.

> The training plan is due to the Agency within ten business days of the first of October. If the training plan is updated, then the updates are due to the Agency within three business days of the update to the plan.

Steps for the training plan are as follows:

1. Determine the type of workshops based on provider issues, program policy changes, and customer requirements. The number of workshops is determined according to provider and claim types.
2. Determine the workshop locations based on provider population and other geographical factors. The range of dates for each workshop is scheduled according to presentation topics and expected provider attendance. Experience has shown that workshops are most widely attended in Birmingham, Huntsville, Mobile, and Montgomery. Other workshop sites can include Dothan and Tuscaloosa.
3. Determine the conventions provider representatives should attend throughout the year.
4. Discuss other meetings that should be conducted between DXC and Medicaid for the upcoming fiscal year.

5.2.2 On-Site Visits

Provider representatives approach training of providers as pro-active. A Provider representative conducts on-site visits with providers as requested. They try to reach out to all providers enrolled in the Medicaid program to let them know help and training are available whenever needed. When a representative is traveling to a particular area, reports are generated to identify providers within the area to offer a visit. This approach lets providers know representatives are available to assist in resolving any issues the provider may encounter. Provider representative contact information is also regularly published in the Provider Insider.

Provider representatives visit providers one-on-one to assist in recognizing and solving problems, which can be initiated by a request from:

- Medicaid Agency
- Provider Review Unit
- Mailroom/data entry
- PAC/Adjustments/Enrollment/ECS
- The provider
- Provider Representative Supervisor

Visits may also be prompted by ECS calls or a review of:

- The monthly or quarterly reports.
- The DSS reports listing providers in a particular area.

Although the Alabama Medicaid Agency does not contractually require a minimum number of visits, representatives are requested to meet with providers weekly. This ensures the representatives are meeting and training providers; reaching out to the provider community and building strong relationships. If a representative cannot meet with providers in a given week, the representative should notify the supervisor of the reason, giving contact information on providers not wanting a visit.

For quality assurance, each representative must leave a postcard evaluation for the provider to evaluate the quality of the representative's visit. The card should be filled out after the representative leaves, and should be returned to the representative supervisor. The representative supervisor and the representative review the completed evaluation postcards prior to forwarding them to the Alabama Medicaid Agency for review. The representative supervisor follows up on any problem visits or unresolved issues. The supervisor or team leader may also accompany the representative or contact providers after visits have been made to discuss the quality of the visit.

Representatives have lists of general topics and information that should be covered while on provider visits. Representatives also make 'cold call' unscheduled provider visits. While this is not the preferred method of visiting providers, it is acceptable. If the biller has questions, the representative offers assistance as appropriate. If the biller does not have any questions, the representative should thank them for their time and encourage them to contact the account for assistance. When the biller has no questions, the contact is identified as a 'non visit' and the visit does not count toward the representative's weekly total. We document the 'non visits' to show the Agency our outreach efforts to providers which are not experiencing problems.

After each provider visit, representatives document all covered topics during the visits. The contact sheets are reviewed by the representative supervisor for content prior to being delivered to the Agency on a monthly basis.

In addition to training the provider community, the provider representatives also train other DXC staff members when there is a program change, update, or enhancement to the system. Any instructional material necessary to train DXC staff members is developed by the representatives after the notification of a change. The representatives determine if departments within DXC need training. Training sessions are scheduled with staff members in coordination with the DXC trainer/documentation specialist.

Provider Representatives also train Agency staff members. The training could be on a number of different topics. Some of which include:

- AMMIS Panels
- New Programs
- Refresher training on billing

Training to new Agency programs

6 PROVIDER ASSISTANCE CENTER

A Provider Assistance Center (PAC) Representative is an individual who has acquired knowledge of the Alabama Medicaid program through extensive training, study of the provider manuals, user documentation, and on-the-job experience. The PAC Representative interacts with the provider community through verbal and written communication regarding the following:

Billing problems

Billing procedures

Claims status

General inquiries

Medical policy

Prior authorization status

Remittance Advices (RAs)

Each PAC Representative has access to a desktop computer. This equipment allows the representative to provide accurate and timely answers during telephone conversations through immediate online research of numerous AMMIS panels.

6.1 PROVIDER SUPPORT

The PAC maintains a minimum of 16 incoming toll-free lines with the capacity of up to 40 for provider support. The Alabama Medicaid provider community uses the toll-free telephone lines to obtain claim status, prior authorization status, billing procedures, medical policy, and Medicaid eligibility and benefits information.

> To meet both the expectations of the provider community and contract obligations, PAC telephone lines are staffed from 8 AM until 5 PM local time on Monday through Friday. The staffing requirement excludes DXC-observed holidays.

All PAC representatives are on an Automated Call Distribution system (ACD), which distributes a call to the next available PAC representative not engaged on another line. If a PAC Representative is completing research, the representative can be excluded from the ACD system by a using a specific touch-tone telephone command.

6.1.1 Call Tracking

The Provider Assistance Center utilizes Helpdesk Expert Automation Tool (HEAT) by FrontRange Solutions. HEAT is used in the Provider Assistance Center to automatically log and track all verbal, written, and walk-in inquiries from the provider community associated with the Provider Assistance Center. HEAT displays the history of the caller once the provider number is entered**.** The system will record the date of inquiry, the Provider ID, the form of the inquiry, the specific nature of the inquiry, the form of response, the date of response, the respondent, and the relevant comments. This information will be stored in a database that is accessible by provider number and will automatically appear on the staff member's screen after the provider number is entered. If a provider does not enter a number, after answering the call, the associate will enter the information into the call tracking system, and the provider history will appear on the screen.

6.1.2 Telephone Etiquette

In most cases, the PAC unit is the first contact the provider has with DXC. Because first impressions with the provider community are critical to the success of the Medicaid process, a PAC Representative must follow the telephone etiquette rules outlined in the below table.

Telephone Etiquette

Appropriate	Inappropriate
DXC, Good Morning/Afternoon, this is (your name), How may I help you?	DXC
Let's work together to resolve the issue.	That's the State's fault, not ours.
May I put you on hold, please?	Hold on.
I understand why you are upset.	I am so sorry, I feel so badly.
I'm sorry, I did not understand you.	I can't hear you--huh?
Yes ma'am/sir.	Uh-huh.
Thank you for calling, Good-bye.	Bye.

A PAC Representative must adhere to the following:

Do not leave a caller on hold for more than one minute.

Do not lay the telephone down without first placing the caller on hold or using the mute feature on the telephone, so the caller cannot hear conversation while waiting.

NOTE:

Refer to the INTER-TEL Executone Phone User's Guide for additional information on the basic telephone functions.

Telephone Research

The below table indicates the type of calls that will require immediate attention from the PAC Representative.

A PAC Representative is committed to completing–by the end of the next business day–all telephone inquiries that require follow-up or a return call.

The table provides a list of the types of calls and the necessary research tools used to respond appropriately.

Telephone Research

Type of Inquiry	Procedure
Claim Status	Access the Claims Search panel. To access the panel, point to Claims and click Search. The representative must enter at least one of the following to perform a search: ICN, Recipient ID, Provider ID, Rendering Provider ID. Determine if the claim has been paid, denied, or is suspended and convey the information to the provider. For paid and denied claims, provide both the payment amount and date of payment or the Explanation of Benefit (EOB) denial code and date of denial. For claims in a suspended status, inform the provider of the reason and that there is no further action required of the provider at this time. If the claims are not found, relay this information to the provider and request that the claims be resubmitted. This is also a good opportunity to inform the provider about the PES software for claims submission and recipient eligibility verification.
Check Amount	Access the FPS Financial Payment Search panel. To access the panel, point to Financial and click Payment. The representative must enter at least one of the following: (Payee Type & Payee ID) OR Payment Number OR Date Range.
Recipient Eligibility/Available Benefits	Access the Recipient Information Page. To access the panel, point to Recipient and click Information, then enter current ID or case ID, and click search. Available eligibility benefits can be obtained via the Recipient Service Usage Panel. To access the panel, point to Recipient and click Service Usage, then enter the RID or SSN, and click search. This panel contains valuable data for determining eligibility for various benefits such as vision checkups, frames, lenses, etc. This type of call is handled only when there is an issue with the AVRS line.
Procedure Code Coverage	Access the Procedure Information panel. To access the panel, point to Reference and click Procedure, enter search criteria, and click search. The representative will answer questions regarding procedure code coverage using the Procedure Information panel and relevant panels that may be accessed through the Procedure Maintenance panel.

NOTE:

Refer to the AEVCS User Manual for additional information.

On occasion, a provider may request information that is restricted. The PAC Representative is not allowed to convey any confidential information and must decline to answer the request due to Medicaid policy provisions.

Call Log

The Provider Assistance Center has several reports that are generated daily from the telephone system. These reports are utilized to monitor the total number of calls into the center, the number of calls each representative accepted, total hold time, number of abandoned calls, and number of calls transferred into the center. These numbers are captured and are delivered to the state in the form of a monthly status report.

6.1.3 Additional Tasks

When there are no incoming calls, a PAC Representative works on research, and completes the following tasks:

Answer written correspondence

Complete and log Return to Provider (RTP) letters

Research all call backs

Written Correspondence

The mailroom delivers all provider inquiries to Provider Services on a daily basis. A designated analyst separates the mail into batches and files them according to Julian date receipt. The correspondence is generally received in one of the following formats:

Provider Inquiry form.

Provider-generated letter.

An inquiry written on the provider's remittance advice.

The method of processing the inquiry is the same regardless of which type of correspondence is received.

> A PAC Representative or a Provider Representative receives and responds to written correspondence submitted by providers within seven business days of receipt.

Provider Services completes the following steps when replying to the written provider correspondence:

1. The mailroom delivers the mail addressed to Provider Services.
2. After the mail is delivered, each provider inquiry is assigned a Letter Control Number (LCN) and batched in groups of 50 inquiries. The following information is then entered into the Correspondence Tracking System (CTS) using the Provider Correspondence Batch Control window:

LCN information

Provider NPI number

Date received

PAC clerk ID

3. After the written correspondence analyst has sorted, batched, and recorded the inquiries, the inquiry is ready for research. The PAC analyst accesses the CTS and types the batch number in the Provider Correspondence Inquiry Response window. The inquiry is displayed; the PAC analyst reads the inquiry, and types a valid inquiry code and brief description of the inquiry.
4. The PAC analyst completes the necessary research, using the various AMMIS panels and the appropriate reference materials.

5. The PAC analyst types a response in the free-text area on the Inquiry Response window. When this process is completed, the analyst generates the appropriate inquiry response from a pull-down menu that displays the various provider response letters. The body of each letter is completed from the free-text area that has already been typed by the analyst.
6. If the analyst cannot answer the inquiry immediately, the inquiry is placed in an Open Status Awaiting Additional Research. Once the research is completed, the analyst accesses the system and generates the provider response letter.
7. The letters are printed in Operations, and returned to Provider Services.
8. The PAC analyst verifies the response for accuracy prior to mailing to the provider.
9. The correspondence is sent to the mailroom for scanning.
10. The PAC analyst changes the status to Closed on the CTS for the correspondence.

6.1.4 HIPAA Procedures

1. All Provider Assistance Center representatives have been trained on HIPAA privacy standards. When a provider calls into the center, the provider NPI number is verified against the provider file for validation. If a provider enrollment has expired, associates are not allowed to release information to that provider.

If a suspicious call is received in the area, the information is forwarded to the HIPAA Privacy for investigation.

7. GLOSSARY

The table below defines the terms used in the Provider Services functional area.

Provider Services Functional Area Terms

Term	Definition
AEVCS	Alabama Automated Eligibility Verification and Claim Submission system.
CHOW	Change of Ownership
NPI	National Provider Identifier
Provider Enrollment	Unit within Provider Services that is responsible for enrolling providers in the Alabama Medicaid program.
Provider Assistance Center	First point of contact with Provider Services when a provider has a billing or Medicaid related question.
Provider Representative	Individual that works with providers participating in Alabama Medicaid. This includes training, education, and support for provider issues.